Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 5 June 2014; 1330h

Members

Mr R Samuda	(RSM)	[Chairman]
Ms C Robinson	(CRO)	[Vice Chair]
Dr S Sahota OBE	(SS)	[Non-Executive Director]
Mrs G Hunjan	(GH)	[Non-Executive Director]
Ms O Dutton	(OD)	[Non-Executive Director]
Mr H Kang	(HK)	[Non-Executive Director]
Dr P Gill	(PG)	[Non-Executive Director]
Mr T Lewis	(TL)	[Chief Executive]
Mr C Ovington	(CO)	[Chief Nurse]
Miss R Barlow	(RB)	[Chief Operating Officer]
Mr T Waite	(TW)	[Director of Finance]
Dr R Stedman	(RST)	[Medical Director]

In attendance

Mr M Hoare	(MH)	[Non-Executive Director]
Miss K Dhami	(KD)	[Director of Governance]
Mrs C Rickards	(CR)	[Trust Convenor]

Guests

Patients for patient story & service presentation

Secretariat

Mr S Grainger-Lloyd (SGL) [Trust Secretary]

Time	Item	Title	Reference Number	Lead
1330h	1	**Apologies**	Verbal	SG-L
	2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	SWBTB (6/14) 074	SG-L
	3	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 1 May 2014 a true and accurate records of discussions*	SWBTB (5/14) 072	Chair
	4	**Update on actions arising from previous meetings**	SWBTB (5/14) 072 (a)	SG-L
	5	**Questions from members of the public**	Verbal	Public
1340h	6	**Patient story**	Presentation	CO
1400h	7	**Chair's opening comments and Chief Executive's report**	SWBTB (6/14) 075	RSM/ TL
		MATTERS FOR DISCUSSION AND APPROVAL		
1410h	8	**Annual Accounts – Year ended 31 March 2014**	SWBTB (6/14) 076 SWBTB (6/14) 076 (a) SWBTB (6/14) 076 (b)	TW
1420h	9	**2013/14 audit memorandum**	SWBTB (6/14) 077	TW
1425h	10	**Letter of representation**	SWBTB (6/14) 078	TW
1430h	11	**2013/14 Annual Governance Statement**	SWBTB (6/14) 079 SWBTB (6/14) 079 (a)	TL

Time	No.	Item	Paper	Lead
1435h	**12**	**Quality Account 2013/14**	**SWBTB (6/14) 080 SWBTB (6/14) 080 (a) - SWBTB (6/14) 080 (c)**	**RST**
1445h	**13**	**Capital Plan 2014/15**	**SWBTB (6/14) 081 SWBTB (6/14) 081 (a)**	**TW**
1500h	**14**	**Finance performance report 2014/15 – Month 1**	**SWBTB (6/14) 082 SWBTB (6/14) 082 (a)**	**TW**
1510h	**15**	**Corporate integrated performance dashboard**	**SWBTB (6/14) 083 SWBTB (6/14) 083 (a)**	**TW**
1520h	15.1	18 weeks improvement plan	SWBTB (6/14) 084 SWBTB (6/14) 084 (a)	RB
1530h	**16**	**Trust Risk Register update**	**SWBTB (6/14) 085 SWBTB (6/14) 085 (a) - SWBTB (6/14) 085 (c)**	**KD**
1540h	**17**	**Annual plan 2013/14 update – red and amber areas**	**SWBTB (6/14) 086 SWBTB (6/14) 086 (a)**	**TL**
1550h	**18**	**Timetable for the sign off of five year plan submissions to the Trust Development Authority**	**SWBTB (6/14) 087 SWBTB (6/14) 087 (a)**	**TW**
		PRESENTATION		
1600h	**19**	**Service update - Pharmacy**	**Presentation**	**RB**
		UPDATES FROM THE COMMITTEES		
1615h	**20**	**Update from the meeting of the <u>Public Health, Community Development and Equality</u> Committee on 29 May 2014 and minutes of the meeting held on 27 February 2014**	**SWBPH (2/14) 005**	**RSM/ TL**
	21	**Update from the meeting of the <u>Quality & Safety</u> Committee on 30 May 2014 and minutes of the meeting held on 25 April 2014**	**SWBQS (4/14) 036**	**OD/ CO**
	22	**Update from the meeting of the <u>Finance & Investment</u> Committee held on 30 May 2014 and minutes of the meeting held on 28 March 2014 and 16 May 2014**	**SWBFI (3/14) 019 SWBFI (3/14) 020**	**CR/ TW**
	23	**Any other business**	**Verbal**	**All**
		MATTERS FOR INFORMATION		
1625h	**24**	**Midland Metropolitan Hospital project: monitoring report**	**SWBTB (6/14) 088**	
1630h	**25**	**Foundation Trust application programme: monitoring report**	**SWBTB (6/14) 089**	
	26	**Details of next meeting** *The next public Trust Board will be held on 3 July 2014 at **1330h** in the Anne Gibson Boardrooms, City Hospital*		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

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REGISTER OF INTERESTS AS AT MAY 2014

Name	Interests Declared
Chairman	
Richard Samuda	▪ Director – Horton's Estates Ltd. ▪ Director – 'Kissing It Better' ▪ Non Executive Director – Warwick Racecourse
Non Executive Directors	
Clare Robinson	▪ None
Gianjeet Hunjan	▪ College Finance and Administration Team Manager – University of Birmingham ▪ Lay Member – Advisory Committee on Clinical Excellence Awards – West Midlands ▪ Lay Member – NHS Midlands and East Workforce Deanery ▪ Governor – Oldbury Academy ▪ Governor – Ferndale Primary School
Sarindar Singh Sahota OBE	▪ Trustee – Acorns Hospice ▪ Member – Court of University of Birmingham ▪ Trustee – Nishkam Education Trust ▪ Director – Asian Business Forum ▪ Member – Smethwick Delivery Board ▪ Chair – Birmingham City Council Citizen-Led Quality Board for Assessment and Support Planning
Harjinder Kang	▪ Managing Consultant – PA Consulting Group
Olwen Dutton	▪ Partner – Bevan Brittan LLP ▪ Fellow – Royal Society of Arts ▪ Member – Lunar Society ▪ Member – Birmingham Forward ▪ Member – Council of the Birmingham Law Society
Paramjit Gill	▪ Trustee South Asian Health Foundation ▪ Trustee – Healthy Hearts ▪ Clinical Academic at University of Birmingham collaborating with colleagues based at the Trust on a number of research studies
Executive Directors	
Toby Lewis (Chief Executive)	▪ Board member – Sandwell University Technical College
Rachel Barlow (Chief Operating Officer)	None
Colin Ovington(Chief Nurse)	None

Roger Stedman (Medical Director)	▪ Partner – Excel Anaesthesia (private anaesthesia services)
Tony Waite (Director of Finance & Performance Mgt)	None
Associate Members	
Kam Dhami (Executive)	▪ None
Michael Hoare (Non Executive)	▪ Director, Fujitsu UK
Trust Secretary	
Simon Grainger-Lloyd	▪ Director – Parkfields Management

May 2014

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.2

Venue Anne Gibson Boardroom, City Hospital **Date** 1 May 2014

Present

Mr Richard Samuda [Chair]
Ms Clare Robinson
Dr Sarindar Sahota OBE
Mrs Gianjeet Hunjan
Mr Harjinder Kang
Ms Olwen Dutton
Mr Toby Lewis
Mr Tony Waite
Mr Colin Ovington
Miss Rachel Barlow
Dr Roger Stedman

In Attendance

Mr Mike Hoare
Miss Kam Dhami

Guests

Patient
Patient's husband
Sister Julie Guy
Matron Donna James
Mrs Fiona Shorney

Secretariat

Mr Simon Grainger-Lloyd

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
Apologies were received from Dr Paramjit Gill.	
2 Declaration of Interests	**Verbal**
There were no declarations received since the last meeting.	
3 Minutes of the previous meeting	**SWBTB (4/14) 059**
The minutes of the Trust Board meeting held on 3rd April 2014 were presented for	

consideration and approval. The Board agreed that they represented an accurate reflection of discussions held at the previous meeting.	
4 Update on Actions arising from Previous Meetings	**SWBTB (4/14) 059 (a)**
The Board received the updated actions log. It was noted that there were no actions outstanding or requiring escalation to the Board for resolution.	
5 Questions from members of the public	**Verbal**
There were no members of the public.	
6 Patient story	**Presentation**
The Board was addressed by a patient who had been treated a patient on wards Lyndon 2, Newton 2, in addition to experiences in Priory 2, the Emergency Assessment Unit and the Accident & Emergency Department at Sandwell Hospital. The experience outlined was reported to have been mixed, with the experience on Newton 2 being reported to be positive whereas the experience on Lyndon 2 had been poor. The Board listened to the detail of the patient's experience. The Chairman apologised for the poor experience on behalf of the Trust. Ms Dutton asked what the patient suggested needed to be done to address the issues she had experienced. The patient advised that training in better respect for patients was needed. It was noted particularly that the nurses working on Lyndon 2 had behaved poorly and appeared to be unhappy. Mrs Hunjan noted that it had appeared that the hand hygiene practice varied between wards. The administration of pain relief was reported to be different between the two wards. Mr Lewis explained the intended practice for pain relief administration. He asked whether the medical history was available when the patient attended the Accident and Emergency Department. He was advised that this was largely the case, however the way in which the patient was addressed in the Department varied considerably. Miss Barlow suggested the use of a letter kept by the patient which documented the key elements of the patient's medical history would be beneficial in this case. She also asked what could be done better to communicate with GPs following discharge. It was noted that there was a disparity between the TTO discharge letter and the GP instructions regarding medication. Mr Kang asked whether the patient had voiced her concerns about Lyndon 2 during her stay on Newton 2. The patient confirmed that this was the case, however there had been little acknowledgement of the issued aired by the nursing team on Newton 2. The Chairman asked whether the senior managers were visible on Lyndon 2. He was advised that there was regular senior presence on the wards which could be	

accessed if needed. Mr Ovington summarised the issues that required addressing and highlighted that these correlated with some of the findings from the patient survey. The Chairman noted that some of the themes in the patient story were consistent with some of the previous patient stories heard by the Board. Mr Hoare suggested that the timescales for the actions and points of learning from the patient story heard at the April meeting needed to be revisited. Ms Robinson asked how the points of learning were addressed as expeditiously as possible. Mr Ovington advised that this depended on the issue concerned, however in this instance, addressing pain management would be picked up quickly, whereas the attitudinal issues reported needed to be tackled over a longer timescale. Miss Dhami reported that the lessons learned from complaints and incidents were considered at the Executive-led committees. She added that as part of the devolved model, it was the responsibility for dissemination of these at a Group level. Miss Dhami advised that following the patient story in April, she had reviewed the complaints associated with the areas in overview and noted that there had not been a formal trend of complaints, which suggested therefore that complaints could not be used as a quality indicator in isolation. Mr Lewis acknowledged the weaknesses around understanding whether the actions in the plans had been delivered and were delivering effective results. It was also reported that the learning between experiences needed to be further developed. Ms Dutton reported that there had been a discussion at the recent Quality & Safety Committee around the learning from complaints and issues. She added that it had been agreed that there would be a quarterly 'deep dive' into key issues and learning from complaints and serious incidents. The Board agreed that this was an appropriate response to learning from issues. Ms Dutton advised that the Quality & Safety Committee would also be considering the key themes from the patient stories presented to date which would then be communicated to the Board. Mr Lewis suggested that to provide greater assurance to the Board on the issues raised in the patient stories, there needed to be a better understanding of the pace around addressing the issues and the evidence that could be provided that matters were being handled robustly.	
ACTION: Executive to consider the evidence that could be provided to assure the Board that issues raised during patient stories were being handled robustly	
7 Chair's opening comments and Chief Executive's report	**Hard copy**
Mr Samuda reported that he had attended the Trust Development Authority's Chairs' and Chief Executives' forum recently, which had focussed on the financial influences on the NHS at present including the need for transformational cost savings plans. Mr Lewis reported that with effect from April, the contractual arrangements had	

been assumed by the Trust in respect of the third party GP service in the Accident and Emergency Departments. He reported that 'First Friday' would commence from 2 May 2014, meaning that the senior managers would be visiting number of areas across the Trust. Following a meeting with the TDA, it was reported that the inspection by the CQC Chief Inspector of Hospitals was likely to be scheduled for Quarter 3. It was reported that the resolution made by the Board in November in respect of the Midland Metropolitan Hospital was at a key stage given that the Trust was not at a point where the plans could progress at present.	
8 Financial plan 2014/15	**Hard copy**
Mr Waite reported that his report was provided as supplementary information to the financial plan agreed at the April meeting of the Board. He advised that the granularity of the financial management information presented was consistent with the organisation of the Trust's directorates. It was reported that the information was provided with due regard to transparency and aimed to communicate the magnitude of the task to ensure that the financial plan was delivered for the year. Mr Waite reported that there was further work needed to secure a full savings plan which was reported to be considered in a separate meeting of the Finance and Investment Committee. The Chairman asked what dialogue was underway with GPs to assist with the delivery of the plan. Miss Barlow reported that the clinical leads were working with GPs on a series of demand management initiatives, including around orthopaedics and diagnostic requests. It was reported that direct access for Cardiology was being arranged in line with the Map of Medicine. Work was reported to be underway with other areas to refine the pathways for general surgery and respiratory. Mr Kang asked whether there was confidence in the sufficiency of the GPs' capacity and capability to deliver this work. He was advised that although there were some practices where the work would be met with difficulty, by gaining the support of the majority of GP practices, the overall programme would be supported. Dr Stedman advised that much GP engagement was underway. Mr Lewis reported that there were some good opportunities to influence the GP referral practice, however this needed to be balanced with business loss. It was reported that there was a trend towards more diagnostic direct access and focussed attention would be directed to this within the year. Mr Lewis suggested that further work was needed on the risk analysis associated with the financial plan, including consistency with the Trust's overall risk management processes. Ms Robinson noted the move in the financial benefit associated with the Birmingham and Black Country Community Trust. Mr Waite reported that there were a number of contractual arrangements which had been tidied, including the move to more national pricing arrangements such as that associated with the Birmingham and Black Country Community Trust. Ms Robinson asked how costs would be managed in the area in response to these changes. She was advised that the area would be supported in their attempt to respond to the changes. Mr Lewis added that the work was being addressed through the rebasing of budgets. Ms Robinson observed that the matter represented a significant cost pressure for	

the Trust. It was agreed that the scale of the challenge needed to be clearly articulated at the next meeting of the Finance & Investment Committee. Ms Robinson observed that the level of information was considerable and asked whether it was appropriate to consider it in public. It was agreed however that the information was disclosable under Freedom of Information legislation and that in the interests of transparency it was appropriate to consider it in public. Mr Waite reported that remedial action was being taken to address the gap in the savings plan for 2014/15 and that there was a good deal support with the organisation in helping the organisation to understand the challenge and supporting the teams with identifying and delivering the savings. Mr Lewis reported there a number of measures that had been undertaken to support the finalisation of the savings plan, including the expansion of the change team to assist with this work. It was also highlighted that there had been a significant investment in leadership and external support with transforming concepts into plans. Some benchmarking work was also reported to be underway. Mrs Hunjan asked whether the work included the budget and nurse establishment harmonisation. Mr Waite reported that work had been undertaken to understand what spend by area had been for 2013/14 and then nurse staffing establishments and budgets had been aligned based on this. It was suggested that the accrual for some types of invoices needed to be given further thought and that this would be discussed with the Finance & Investment Committee. The way in which the reconciliation between budgets and establishments was discussed. It was noted that there was a move away from holding a significant level of reserves centrally which presented a degree of risk. Mrs Hunjan noted the need for robust monitoring of the plan throughout the year given the difference in approach. Mr Lewis reported that as part of the reconciliation work, should a vacancy be held for more than 8 weeks, then the Executive-led workforce committee would consider the future of the post. Dr Sahota asked whether there was a trend in increased activity for accident and emergency activity. He was advised that should accident and emergency activity increase to some degree there was little financial risk exposure. In 2015/16, it was noted that there was an expectation that the activity in this area would be flat.	
ACTION: **Mr Waite to present the following at the May meeting of the Finance & Investment Committee: change in the approach to financial management between 2013/14 and 2014/15; accrual handling; cost pressures associated with normalising of contractual arrangements; details and progress of the work to devise the full TSP for 2014/15**	
9 Financial performance report – Month 12	**SWBTB (5/14) 061** **SWBTB (5/14) 061 (a)**
The Board was asked to receive and note the financial position for Month 12, which reflected that all key financial targets had been met and that the annual accounts had been submitted for auditing on time.	

It was reported that the Trust was not overspent on pay during the year, despite the suggestion that this was the case from the technical position at Month 12.	
10 Corporate performance dashboard	**SWBTB (5/14) 062** **SWBTB (5/14) 062 (a)**
Mr Waite reported that the performance against the emergency care target had been met and that there had been an improvement in performance against the stroke thrombolysis target. Cancelled operations were noted to have reduced. It was reported that there had been a breach to the 28 day cancelled operations target and that the fractured neck of femur performance was poorer than desired. The Board was informed that mixed sex accommodation breaches were unacceptably high and medicines management CQuIN target had not been met. Miss Barlow provided the detail on the improved emergency care performance. She added that an electronic means of recording mixed sex accommodation breaches had been introduced, which had exposed some of the breaches that were not otherwise obvious previously. The non-clinical dimension of the performance against the fractured neck of femur target was reported to be influenced by the day of week or national holidays. It was reported that a learning event had been held around the breach to the 28 day cancelled operations guarantee. Mr Lewis asked what the financial exposure was likely to be around medicines management in 2014/15. He was advised that this was not a target in the current financial year.	
10.1 Rapid access chest pain performance	**Verbal**
Miss Barlow reported that there had been variance in performance between the two sites on performance against the rapid access chest pain performance, which lay with the administration procedures around these. Further work was planned to address this. Mr Lewis noted that data for performance against the Cardiology-related targets was not available, which Miss Barlow advised would be investigated further. It was noted that the performance against the targets was currently unacceptable and a discussion around Cardiology was necessary at the next private meeting of the Board. It was agreed that the plans to establish a new cathode lab needed to be considered in this context.	
ACTION: Miss Barlow to present an update on the Cardiology recovery plan at the next private Board meeting	
10.2 Performance against the 18 week referral to treatment time target	**SWBTB (5/14) 063**
Miss Barlow provided a presentation around the performance against the 18 week referral to treatment time target. The presentation covered current performance; waiting list details; the position by speciality and plans to decrease the backlog of patients waiting over 18 weeks; the plans to address the position in 2014/15; and redesign of patient pathways. It was noted that the recovery plan against the target was feasible, including the	

plans to support Cardiology. The Chairman asked for an indication of the clinical morale and engagement around the plans. He was advised that in some areas there was good engagement and transformation, although the challenges with achieving this across the Trust were more difficult. It was noted that the engagement of the Breast services speciality was particularly pleasing. Mr Lewis noted that the Trust's performance was better than a number of other organisations and he asked that Miss Barlow prepared an analysis to highlight the number of patients who would be who would be treated under the 18 weeks pathways and the likely waiting times expected.	
ACTION: **Miss Barlow to prepare an analysis to highlight the number of patients who would be treated under the 18 weeks pathways and the likely waiting times expected**	
11 Safe staffing	**SWBTB (5/14) 064** **SWBTB (5/14) 064 (a)**
Mr Ovington reported that there had been an instruction received from the Department of Health recently to publish nurse staffing data, which he noted had already been undertaken at ward level from February. It was noted that the information needed to be received by the Board monthly with a report being produced quarterly. The Board was advised that the use of e-rostering was being investigated with a view to populating this information. It was noted that the information would be based on funded establishments and needed to display the numbers of staff rather than ratios. Mrs Hunjan advised that she had noted as part of her recent visit to the neonatal unit, the nurse staff numbers were available, although she highlighted that this did not necessarily reflect the desired registered nurse to patient ratio. It was noted that the mandated publication of nurse staffing information was being extended to Paediatrics and Maternity as a next step. Mr Lewis drew the Board's attention to the recommendation to the recommendation from the Chief Nurse that there was no intention to rebalance the night time and daytime staff ratios in line with the suggested 1:8 requirements. It was noted that this was a conscious decision not to do this at present but would be revisited in July 2014. Dr Stedman suggested that the risks on a ward by ward basis concerned with staff ratios and that the staffing levels needed to be considered in the context of the provision of safe care for patients. It was reported that the matter had been discussed with the senior nursing team and that rosters needed to be completed well in advance to better plan the use of temporary staff. Mr Colin reported that nurse staffing levels were set within parameters and that a validation exercise would be undertaken to understand the impact of 'specialling'	

and the way in which staffing levels are set. Miss Barlow suggested that it would be useful to look at stroke and care of the elderly therapies staff needed to be considered as part of the work. The Board supported the proposed publication of the nurse staffing information.	
12 Trust risk register update	**SWBTB (5/14) 065** **SWBTB (5/14) 065 (a)**
Miss Dhami advised that six risks were included in the Trust Risk Register, which were identical to those considered at the last meeting and the treatment plans had not required significant updating. It was highlighted that the details of the risk around Pathology was provided. The list of premitigated red risks were reviewed as requested at the last meeting. Ms Dutton noted that a risk around baby abduction was included although she understood that a baby tagging system was in place. Miss Dhami advised that the system was in place however it had only recently become operational and therefore the risk would remain until such time as the system had been more fully embedded. The risk around payroll processing was discussed. It was noted that the internal audit function would review the programme plan for the implementation of the new system.	
13 Quarter 4 2013/14 annual plan update	**SWBTB (5/14) 066** **SWBTB (5/14) 066 (a)**
Mr Waite asked the Board to receive and note the update, which highlighted the successes and otherwise of the delivery of the annual plan for Quarter 4. It was noted that there was a lack of clarity around the plans for the actions that had been delayed into 2014/15. It was agreed that these needed to be actively considered as part of the Board Assurance Framework and risk register. It was agreed that the plans for the amber and red actions would be presented at the next meeting. The Chairman asked whether equality and diversity was included in the 2014/15 plan. He was advised that this was the case. Ms Robinson noted that there appeared to be a lack of resource to deliver some of the actions and encouraged thought to be given as to how this might be addressed. She also encouraged accountability to be reviewed and clarified where needed.	
ACTION: Mr Waite to present the detail of the 2013/14 Quarter 4 annual plan update red and amber actions at the next meeting	
14 Communities and Therapies Group – Rapid response team update	**Presentation**

Mrs Shorney joined the meeting to present an overview of the Rapid Response Team operations. The Chairman asked how the service compared to those in place nationally. He was advised that the 10 minute response time to ED was good compared to other organisations and that the span of the care in terms of the hours of operation was much better than other organisations. It was reported that Social Services were in place at both City and Sandwell Hospital sites, although the effectiveness of operation needed to be harmonised. Mrs Shorney was thanked for her informative presentation.	
15 Update from the meeting of the Audit & Risk Management Committee held on 24 April 2014 and minutes from the meeting held on 30 January 2014	**SWBAR (1/14) 011**
Ms Hunjan presented an overview of the key discussions from the Audit & Risk Management Committee held on 24 April 2014. Mr Waite provided an update on the plans to address the bank reconciliation matter and the intention of reviewing the segregation of duties. It was reported that the title of the Committee be changed from Audit and Risk Management to Audit and Risk Committee. It was agreed that this was a matter that needed to be discussed outside of the meeting.	
16 Update from the meeting of the Quality & Safety Committee held on 25 April 2014 and minutes from the meeting held on 28 March 2014	**SWBQS (3/14) 035**
Ms Dutton presented an overview of the key discussions from the Quality & Safety Committee held on 25 April 2014 and minutes from the meeting held on 28 March 2014. It was reported that the Deloitte recommendations had been discussed.	
17 Update from the meeting of the Configuration Committee held on 25 April 2014 and minutes from the meeting held on 28 February 2014	**SWBCC (2/14) 010**
Mr Samuda presented an overview of the key discussions from the Configuration Committee meeting held on 25 April 2014 and minutes from the meeting held on 28 February 2014. The Board's attention was drawn to the Gateway Review which had provided a positive view of the project.	
18 Any Other Business	**Verbal**
There was none.	
Matters for Information	

The Board received the following for information: • Midland Metropolitan Hospital Project: Monitoring Report • Foundation Trust Application Programme: Monitoring Report	**SWBTB (5/14) 067** **SWBTB (5/14) 068**
Details of the next meeting	**Verbal**
The next public session of the Trust Board meeting was noted to be scheduled to start at 1330h on 5th June 2014 and would be held in the Churchvale/Hollyoak Rooms, Sandwell Hospital.	

Signed: ……………………………………………………………….

Name: ……………………………………………………………….

Date: ………………………………………………………………

Next Meeting: 5 June 2014, Churchvale/Hollyoak Rooms @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

1 May 2014, Anne Gibson Boardroom @ City Hospital

Members present: Mr R Samuda (RSM), Ms C Robinson (CR), Dr S Sahota (SS), Mrs G Hunjan (GH), Mr H Kang (HK), Ms O Dutton (OD), Mr T Lewis (TL), Miss R Barlow (RB), Mr T Waite (TW), Dr R Stedman (RST), Mr C Ovington (CO)

In Attendance: Mr M Hoare (MH), Miss K Dhami (KD)

Apologies: Dr Paramjit Gill (PG)

Secretariat: Mr Simon Grainger-Lloyd (SGL)

Last Updated: 30 May 2014

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.273	Equality & diversity – interim position statement	SWBTB (12/13) 255 SWBTB (12/13) 255 (a)	19-Dec-13	Include equality and diversity within the business of a future Board Development session	SG-L	13/06/14	ACTION NOT YET DUE Training slot arranged for 13 June 2014	G
SWBTBACT.277	Complaints handling KPIs	SWBTB (4/14) 049 SWBTB (4/14) 049 (a)	03-Apr-14	Provide an update on the measures to address the issues highlighted in the patient story at a future meeting	CO	13/06/14	Update included on the agenda of the private session of the Trust Board	G
SWBTBACT.278	Complaints handling KPIs	SWBTB (4/14) 049 SWBTB (4/14) 049 (a)	03-Apr-14	Provide an update on performance against the Complaints handling KPIs at a future meeting	KD	31/08/14	ACTION NOT YET DUE Update to Quality & Safety Committee arranged for August 2014	G
SWBTBACT.282	Patient story	Presentation	01-May-14	Consider the evidence that could be provided to assure the Board that issues raised during patient stories were being handled robustly	CO	05/06/14	To be considered as part of the discussion of the patient story in the private session of the Board	G
SWBTBACT.284	Rapid access chest pain performance	Verbal	01-May-14	Present an update on the Cardiology receiver plan at the next private Board session	RB	05/06/14	Included on the agenda of the meeting planned for 5 June 2014	G
SWBTBACT.285	Performance against the 18 week referral to treatment time target	SWBTB (5/14) 063	01-May-14	Prepare an analysis to highlight the number of patients who would be treated under the 18 weeks pathways and the likely waiting times expected	RB	05/06/14	Included on the agenda of the meeting planned for 5 June 2014	G
SWBTBACT.286	Quarter 4 2013/14 annual plan update	SWBTB (5/14) 066 SWBTB (5/14) 066 (a)	01-May-14	Present the detail of the 2013/14 Quarter 4 annual plan update red and amber actions at the next meeting	TW	05/06/14	Included on the agenda of the meeting planned for 5 June 2014	G

SWBTBACT.279	Corporate performance dashboard	SWBTB (4/14) 052 SWBTB (4/14) 052 (a)	03-Apr-14	Determine the rapid access chest pain performance and report back at the next meeting	RB	01/05/14	Provided as a verbal update at the May meeting	B
SWBTBACT.280	Trust Risk Register	SWBTB (4/14) 054 SWBTB (4/14) 054 (a)	03-Apr-14	Present the updated risk register at the next meeting	KD	01/05/14	Included as an update on the agenda of the May 14 meeting	B
SWBTBACT.281	Trust Risk Register	SWBTB (4/14) 054 SWBTB (4/14) 054 (a)	03-Apr-14	Arrange for the detail of the Pathology risk to be presented at the next meeting	KD	01/05/14	Update to be presented at the May meeting of the Trust Board	B
SWBTBACT.283	Financial plan 2014/15	Hard copy	01-May-14	Present the following at the 16 May meeting of the Finance & Investment Committee: change in the approach to financial management between 2013/14 and 2014/15; accrual handling; cost pressures associated with normalising of contractual arrangements; details and progress of the work to devise the full TSP for 2014/15	TW	16/05/14	Presented at the May F & I C meeting as requested	B

KEY:

R	Action highly likely to not be completed as planned or not delivered to agreed timescale.
A	Action potentially will not delivered to original timetable or timing for delivery of action has had to be renegotiated more than once.
Y	Slight delay to delivery of action expected or timing for delivery of action has had to be renegotiated once.
G	Action that is scheduled for completion in the future and there is evidence that work is progressing as planned towards the date set
B	Action that has been completed since the last meeting

CHIEF EXECUTIVE'S REPORT

Report to the Public Trust Board – June 2014

The Board considers this month a series of statutory documents that outline our successes and lessons for improvement from 2013/14. Although many of constrained by statutory form we will work in the weeks ahead to try and ensure that they are each accessible to their primary audience, and overall tell an accurate and candid story about care. Both the annual governance statement and our review paper on 2013/14 objectives and their delivery make implied suggestions for work in 2014/15. That work is within our plans, and may merit consideration in our Board Assurance Framework. In finalising our committee forward plans for the year we need to ensure that no items are unwittingly omitted, albeit some amber-red issues from 13/14 we are intending to set aside.

In addition we examine our capital plans and again examine our 18 week plans. The former represent a major investment in local services. The latter is a key delivery risk on national minimum standards across the NHS and although we met the standard in April more specialties missed the measure than our annual plan anticipated. More importantly waiting matters to patients. In 2013/14 we improved emergency care at the Trust, in 2014/15 we want to achieve similar or better gains in elective care, based on smarter and more compassionate ways of working rather than simply committing more funds to the issue.

1. Our patients

The Board has spent time during 2013/14 on the quality of stroke care provided by the Trust. Reconfiguration between our sites was an important milestone in change, and the opening of additional scanning capability in 2013 was also significant. The data is showing continued improvement in our standards in most areas, and the emerging data across the region suggests that we are among the top three services on most if not all indicators. However, our introduction of a changed way of recording single-sex compliance (dignity of not mixing bays or wards) has illuminated significant challenges on our main stroke ward. We are absolutely committed to resolving these issues not later than the end of June.

Earlier this month, we opened our latest new service at Rowley Regis Hospital. A sexual health (GUM) clinic opened each Thursday evening. We are committed to extending access to such services as rates of infection rise nationally. We look forward to working with Sandwell Metropolitan Borough Council in their new role as commissioner for such services to develop an integrated approach across the borough this year.

The integrated performance report to the Board shows that in April, for the first time in two years, the Trust and our partners met the emergency care standard on all our sites. This demonstrates that, with all of the understood constraints a complex system faces, we are able to achieve what we all want, and our patients deserve. In May performance has faded. We need in June to achieve what we have achieved. That requires action in many areas, but for improvement to become sustained we have to change the delayed transfers of care position in both our acute sites. Trust staff, CCG staff,

City Council staff and Sandwell Metropolitan Borough Council teams need to work differently together if we are to improve on 2013-14 and reverse the significant deterioration in performance since the turn of the year. Existing compacts, partnerships, and arrangements are not succeeding and a new approach is now needed. The Right Care, Right Here partnership will take responsibility for ensuring that all partners deliver on new obligations to improve.

During May, the Trust celebrated International Clinical Trials Day. Earlier this year we made the important appointment of Karim Raza as our new Research and Development Director. His team will be finalising our plans by the end of September for the future of research at the Trust – with an overarching commitment to treble the number of patients that have access to clinical trials. The Trust has some traditional strengths in research on which we want to build. We are also exploring how we can develop further strengths in new areas, including g health services research with the CLARCH, and areas where our demography demands strength, notably sickle cell and thalassemia.

During May, the care of one patient and their family at Sandwell attracted newspaper attention. This occurred after journalists attended an inquest and used evidence given there in their reports. I am meeting with the family concerned again before the Board meets – I have met with them previously – to discuss the outcome of our investigative work. I will provide an oral précis of that position to the Board meeting. We have been very open with staff too that there may be lessons to learn from the situation and that this provides a chance for us to improve care, as well as to apologise for mistakes that were made.

In March 2014 we reviewed as a Board our approach to palliative care. Colin Ovington agreed to act as a champion and sponsor for end of life care, with Olwen Dutton also taking an active interest. We made a promise that during 2014-15 we would introduce a system to examine the lessons from the last year of care provided for patients. We are exploring how quickly we can introduce that system during this summer, so that we enhance our end of life care services, which have demonstrably improved over the last three years.

2. Our colleagues

In May we began a concerted campaign to tackle short-term sickness rates at the Trust. During 2013-14 progress was made on longer-term sickness management, and in our Public Health Plan we have made an investment in improving access to counselling services for staff. Just under half of our sickness (which remains higher than our plans and above NHS average) is made up of short term ill-health. We want to improve sickness management in fifty areas in our Trust that together comprise a significant proportion of the issues. This is part of our Fully Staffed campaign to make sure that when we set establishments, we have our teams in place. The Board's Workforce Committee will oversee progress over the next two quarters.

It is right to note here that our cost improvement implementation plans are a dominant feature of discussions with staff. I believe that we are being candid about the reality of public finances and the need to balance quality and efficiency, whilst never compromising safety. Some changes that may appear minor are issues that generate considerable discussion. Board members will recall that we have just closed our separate car park for consultant staff in an effort to improve car park access on site and reduce side-street use. Meanwhile, we have changed our restaurant provision at City Hospital, closing the longstanding Millers Restaurant and expanding other outlets. Whenever we implement either changes considered a risk or changes that have capacity for considerable

unpopularity we will maintain an on-going review of unintended consequences, and we will do that in both these cases.

I am pleased to be able to confirm two replacement appointments to my executive team. Both may attend the Board as required. Alison Dailly will join us in September from Leeds Teaching Hospitals NHS Trust as a Chief Informatics Officer with responsibility for IT (information transfers to our COO on July 1). And Ruth Wilkin will also join the team In September as our new Director of Communications. The recruitment for the Director of Organisational Development (a Board post) takes place on June 4th.

3. Our partners

The Trust has confirmed two new partners in what we do in recent weeks. We are now able to offer an integrated emergency care 'front door' service as we have taken on responsibility for GP-front end arrangements with Malling Health. In addition we have, after a competitive tender, appointed St Basil's to take the lead in our homeless apprenticeship work on the Sandwell site. Later in 2014 we will open refurbished accommodation for staff working as apprentices in our organisation. Finally, during June, we will celebrate our membership of the Birmingham Chamber of Commerce patrons group. We are one of two senior health organisations, the other being Birmingham Children's Hospital, who are within this important umbrella body. We expect to learn from partners in the public and private sector about best practice, whilst playing a key and active part in the development of the city – both as a Trust and through own charity.

Discussions continue with other bodies about the future governance of the Right Care, Right Here partnership. The Trust remains committed to this work. The next phase of this ten year long collaboration involves a shift from successful pilot projects to a programme at scale to re-shape care in local communities. This is the basis for our own strategic direction as an organisation wanting to become renowned as the best integrated care organisation in the NHS. The partnership requires each organisation to accept some measure of joint responsibility to tackle both the biggest issues faced by our patients and the biggest sustainability issues faced by each partner. Developing the partnership in this spirit is the proposition that we will examine formally at an upcoming partnership board meeting. If we can commit to joint goals and milestones then all parties can re-examine together whether the current network of inter-organisational fines and penalties and the current trajectories for tendering of component services are the most effective way to secure value for residents and patients.

4. Our regulators

The performance report demonstrates continued compliance with external measures. The quality and safety committee will feed back on the two latest mortality alerts received by the Trust. The Trust is compliant with new obligations created by the Trust Development Authority around staffing reporting. We continue to explore our Foundation Trust platform, which is impacted by the timing of any notified CQC inspection, and by the continued delay on Midland Metropolitan Hospital OBC approval. Our June long-term plan submissions to external bodies will assume approval by June 30th consistent with all previous discussions. Revised submissions may be required if external bodies are unable to achieve that latest, and revised, timetable.

5. Hot Topics

The focus of the Hot Topics in June is on our Your Voice system for staff feedback, which we understand is now the most extensive in the NHS. In May we examined the future role of *volunteers* at the Trust. The Board's committee overseeing public health, community development and equality has reviewed plans for change to expand that role which we expect to implement during Q3. It is clear from staff and management feedback the significant contribution already being made by volunteers and the opportunities that we have to expand that further. Our latest partnership with Age Well in Sandwell illustrates the potential to work with other bodies, who already attract volunteer participation to fulfil our wider commitment to improve our engagement in the local communities that we serve.

Toby Lewis
Chief Executive
30 May 2014

Sandwell and West Birmingham Hospitals NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Statutory Accounts for the Year Ended 31st March 2014
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite (Director of Finance and Performance Management)
AUTHOR:	Tony Wharram (Associate Director of Finance)
DATE OF MEETING:	5 June 2014

EXECUTIVE SUMMARY:

This report presents the Trust's statutory accounts for the year ended 31st March 2014 which have been subject to review by the Trust's external auditors and they have indicated their intention to issue a clean audit opinion. The ISA260 report draws attention to unadjusted audit differences of £4.4m in respect of balance sheet classification but which are not considered material to that opinion.

The Trust is requested to provide a Letter of Representation in support of the accounts which is attached for the Board's consideration

The accounts demonstrate that the Trust met its financial duties for the year 2013/14.

REPORT RECOMMENDATION:

The Board is recommended to

- accept the Audit & Risk Management Committee's recommendation to adopt of the accounts
- consider and confirm that the proposed representations in the Letter of Representation are fair and complete

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	x	

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	x	Environmental		Communications & Media	
Business and market share		Legal & Policy	x	Patient Experience	
Clinical		Equality and Diversity		Workforce	

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Good governance and transparency in financial reporting

PREVIOUS CONSIDERATION:

Audit & Risk Management Committee on 5 June 2014

FOR DECISION

Sandwell and West Birmingham Hospitals NHS
NHS Trust

STATUTORY ACCOUNTS FOR THE YEAR ENDED 31ST MARCH 2014

Report to the Trust Board on 5th June 2014

1 EXECUTIVE SUMMARY

1.1 The Trust's statutory accounts for the year ended 31st March 2014 demonstrate that the Trust has achieved all its financial duties for the year with an overall retained deficit of (£2,505,000) which converts to a surplus of £6,751,000 against its DoH performance target.

1.2 The accounts have been subject to review by the Trust's external auditors and they have indicated their intention to issue a clean audit opinion. The ISA260 report draws attention to unadjusted audit differences of £4.4m in respect of balance sheet classification but which are not considered material to that opinion.

1.3 The Trust is requested to provide a Letter of Representation in support of the accounts. The Board should consider and confirm that the proposed representations are fair and complete.

2 INTRODUCTION

2.1 Attached to this report are the Trust's statutory accounts for the year ended 31st March 2014. They are in a standard format prescribed by the Department of Health and produced on a standard template issued by the Department.

2.2 The accounts in draft form were reviewed at the meeting of the Audit Committee on 24th April 2014 and the audited accounts further considered at the meeting of the Committee earlier today.

2.3 Following the audit of the accounts, a clearance meeting has been held with the Trust's external auditors (KPMG) and the attached accounts incorporate amendments agreed with the auditors as part of the review process.

3 PERFORMANCE AGAINST TARGETS

3.1 Against its key financial targets for 2013/14, the Trust is reporting the following performance:

Measure	Met?	Target	Actual	Variation	Comments
Break Even	√	£6,736k	£6,751k	+£15k	Original target for Trust was £4,600, uplift to £6,736k agreed in year with TDA.
External Financing Limit	√	£3,015k	(£915)	£3,930k undershoot	Undershoots are permitted, trusts are required not to overshoot.
Capital Resource Limit	√	£21,815k	£21,224k	£591k underspend	Under spending is permitted, trusts are required not to over spend.
Capital Cost Absorption Rate	√	3.5%	3.5%	0%	Actual dividends payable and therefore the absorption rate is recalculated at the year-end based on actual capital employed so a rate of 3.5% is guaranteed.

4 CONCLUSION

4.1 The attached accounts for the year ended 31st March 2014 demonstrate that the Trust has met all its primary financial duties and has posted an overall retained deficit of (£2,505,000) which converts to a surplus of £6,751,000 against its DoH performance target. The Trust met its other primary financial duties.

5 RECOMMENDATION

5.1 The Board is asked to consider the accounts and key matters contained in the ISA260 report and is RECOMMENDED to formally adopt the accounts of the Trust for the year ended 31st March 2014.

5.2 The Board is asked to consider and confirm that the proposed representations are fair and complete.

Tony Waite
Director of Finance and Performance Management
29th May 2014

Data entered below will be used throughout the workbook:

Trust name	Sandwell & West Birmingham Hospitals NHS Trust
This year	2013-14
Last year	2012-13
This year ended	31 March 2014
Last year ended	31 March 2013
This year commencing:	1 April 2013
Last year commencing:	1 April 2012

Accounts 2013-14

Statement of Comprehensive Income for year ended 31 March 2014

	NOTE	**2013-14 £000s**	2012-13 £000s
Gross employee benefits	9.1	**(291,589)**	(284,797)
Other operating costs	7	**(142,873)**	(144,346)
Revenue from patient care activities	4	**396,256**	391,875
Other Operating revenue	5	**42,766**	41,132
Operating surplus/(deficit)		**4,560**	3,864
Investment revenue	11	**129**	146
Other gains and (losses)	12	**(193)**	(139)
Finance costs	13	**(2,284)**	(2,158)
Surplus/(deficit) for the financial year		**2,212**	1,713
Public dividend capital dividends payable		**(4,717)**	(5,154)
Transfers by absorption - gains		**0**	0
Transfers by absorption - (losses)		**0**	0
Net Gain/(loss) on transfers by absorption		**0**	0
Retained surplus/(deficit) for the year		**(2,505)**	(3,441)

Other Comprehensive Income

	2013-14 £000s	2012-13 £000s
Impairments and reversals taken to the Revaluation Reserve	**7,429**	(5,649)
Net gain/(loss) on revaluation of property, plant & equipment	**1,486**	580
Total Comprehensive Income for the year	**6,410**	(8,510)

Financial performance for the year

Retained surplus/(deficit) for the year	**(2,505)**	(3,441)
Prior period adjustment to correct errors and other performance adjustments	**0**	0
IFRIC 12 adjustment (including IFRIC 12 impairments)	**(1,108)**	882
Impairments (excluding IFRIC 12 impairments)	**10,030**	7,990
Adjustments in respect of donated gov't grant asset reserve elimination	**334**	1,092
Adjustment re Absorption accounting	**0**	0
Adjusted retained surplus/(deficit)	**6,751**	6,523

The Trust's reported NHS financial performance position is derived from its Retained Surplus/(Deficit), but adjusted in the statement above for the following:-

a) Net impairment of assets of £8,922,000 which is not considered part of the organisation's operating position (2012/13 £8,772,000).

b) The net impact of changes resulting from the elimination of donated asset and government grant reserves.

The notes on pages 5 to 45 form part of this account.

Statement of Financial Position as at 31 March 2014

	NOTE	31 March 2014 £000s	31 March 2013 £000s
Non-current assets:			
Property, plant and equipment	14	**226,403**	216,669
Intangible assets	15	**886**	924
Investment property	17	**0**	0
Other financial assets		**0**	0
Trade and other receivables	21.1	**1,011**	1,048
Total non-current assets		**228,300**	218,641
Current assets:			
Inventories	20	**3,272**	3,604
Trade and other receivables	21.1	**17,448**	10,446
Other financial assets	22	**0**	0
Other current assets	23	**0**	0
Cash and cash equivalents	24	**41,808**	42,499
Total current assets		**62,528**	56,549
Non-current assets held for sale	25	**0**	0
Total current assets		**62,528**	56,549
Total assets		**290,828**	275,190
Current liabilities			
Trade and other payables	26	**(55,138)**	(43,105)
Other liabilities	27	**0**	0
Provisions	32	**(8,036)**	(10,355)
Borrowings	28	**(1,064)**	(1,211)
Other financial liabilities	29	**0**	0
Working capital loan from Department of Health	28	**0**	0
Capital loan from Department of Health	28	**(2,000)**	(2,000)
Total current liabilities		**(66,238)**	(56,671)
Net current assets/(liabilities)		**(3,710)**	(122)
Non-current assets plus/less net current assets/liabilities		**224,590**	218,519
Non-current liabilities			
Trade and other payables	26	**0**	0
Other Liabilities	27	**0**	0
Provisions	32	**(2,562)**	(3,168)
Borrowings	28	**(27,915)**	(28,966)
Other financial liabilities	29	**0**	0
Working capital loan from Department of Health	28	**0**	0
Capital loan from Department of Health	28	**(1,000)**	(3,000)
Total non-current liabilities		**(31,477)**	(35,134)
Total Assets Employed:		**193,113**	183,385
FINANCED BY:			
TAXPAYERS' EQUITY			
Public Dividend Capital		**161,640**	160,231
Retained earnings		**(19,484)**	(20,260)
Revaluation reserve		**41,899**	34,356
Other reserves		**9,058**	9,058
Total Taxpayers' Equity:		**193,113**	183,385

The notes on pages 5 to 45 form part of this account.

The financial statements on pages 1 to 4 were approved by the Board on 5th June 2014 and signed on its behalf by

Chief Executive: Date:

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2014

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2013	**160,231**	**(20,260)**	**34,356**	**9,058**	**183,385**
Changes in taxpayers' equity for 2013-14					
Retained surplus/(deficit) for the year		(2,505)			**(2,505)**
Net gain / (loss) on revaluation of property, plant, equipment			1,486		**1,486**
Net gain / (loss) on revaluation of intangible assets			0		**0**
Net gain / (loss) on revaluation of financial assets			0		**0**
Net gain / (loss) on revaluation of available for sale financial assets			0		**0**
Impairments and reversals			7,429		**7,429**
Other gains/(loss) (provide details below)				0	**0**
Transfers between reserves		1,372	(1,372)	0	**0**
Transfers under Modified Absorption Accounting - PCTs & SHAs		1,909			**1,909**
Transfers under Modified Absorption Accounting - Other Bodies		0			**0**
Reclassification Adjustments					
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0	**0**
Transfers between Revaluation Reserve & Retained Earnings in respect of assets transferred under absorption		0	0		**0**
On Disposal of Available for Sale financial Assets			0		**0**
Reserves eliminated on dissolution	0	0	0	0	**0**
Originating capital for Trust established in year	0				**0**
New PDC Received - Cash	1,409				**1,409**
New PDC Received/(Repaid) - PCTs and SHAs Legacy items paid for by Department of Health	0				**0**
PDC Repaid In Year	0				**0**
PDC Written Off	0				**0**
Transferred to NHS Foundation Trust	0	0	0	0	**0**
Other Movements	0	0	0	0	**0**
Net Actuarial Gain/(Loss) on Pension				0	**0**
Other Pensions Remeasurement				0	**0**
Net recognised revenue/(expense) for the year	**1,409**	**776**	**7,543**	**0**	**9,728**
Transfers between reserves in respect of modified absorption - PCTs & SHAs		0	0	0	**0**
Transfers between reserves in respect of modified absorption - Other Bodies		0	0	0	**0**
Balance at 31 March 2014	**161,640**	**(19,484)**	**41,899**	**9,058**	**193,113**

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
Balance at 1 April 2012	**160,231**	**(18,622)**	**41,228**	**9,058**	**191,895**
Changes in taxpayers' equity for the year ended 31 March 2013					
Retained surplus/(deficit) for the year		(3,441)			(3,441)
Net gain / (loss) on revaluation of property, plant, equipment			580		580
Net gain / (loss) on revaluation of intangible assets			0		0
Net gain / (loss) on revaluation of financial assets			0		0
Net gain / (loss) on revaluation of assets held for sale			0		0
Impairments and reversals			(5,649)		(5,649)
Movements in other reserves				0	0
Transfers between reserves		1,803	(1,803)	0	0
Release of reserves to Statement of Comprehensive Income			0		0
Reclassification Adjustments					
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0	0
Transfers between Revaluation Reserve & Retained Earnings Reserve in respect of assets transferred under absorption		0	0		0
On Disposal of Available for Sale financial Assets			0		0
Reserves eliminated on dissolution	0	0	0	0	0
Originating capital for Trust established in year	0				0
New PDC Received	0				0
PDC Repaid In Year	0				0
PDC Written Off	0				0
Transferred to NHS Foundation Trust	0	0	0	0	0
Other Movements in PDC In Year	0				0
Net Actuarial Gain/(Loss) on Pension				0	0
Net recognised revenue/(expense) for the year	**0**	**(1,638)**	**(6,872)**	**0**	**(8,510)**
Balance at 31 March 2013	**160,231**	**(20,260)**	**34,356**	**9,058**	**183,385**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED

31 March 2014

	2013-14	2012-13
	£000s	£000s
Cash Flows from Operating Activities		
Operating Surplus/(Deficit)	**4,560**	3,864
Depreciation and Amortisation	**13,673**	14,220
Impairments and Reversals	**8,922**	8,872
Other Gains/(Losses) on foreign exchange	**0**	0
Donated Assets received credited to revenue but non-cash	**(213)**	0
Government Granted Assets received credited to revenue but non-cash	**0**	0
Interest Paid	**(2,218)**	(2,072)
Dividend (Paid)/Refunded	**(4,327)**	(5,594)
Release of PFI/deferred credit	**0**	0
(Increase)/Decrease in Inventories	**332**	326
(Increase)/Decrease in Trade and Other Receivables	**(6,965)**	4,263
(Increase)/Decrease in Other Current Assets	**0**	0
Increase/(Decrease) in Trade and Other Payables	**13,395**	7,545
(Increase)/Decrease in Other Current Liabilities	**0**	0
Provisions Utilised	**(5,643)**	(9,682)
Increase/(Decrease) in Provisions	**2,529**	5,035
Net Cash Inflow/(Outflow) from Operating Activities	**24,045**	26,777
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest Received	**131**	140
(Payments) for Property, Plant and Equipment	**(22,985)**	(15,698)
(Payments) for Intangible Assets	**(210)**	(210)
(Payments) for Investments with DH	**0**	0
(Payments) for Other Financial Assets	**0**	0
(Payments) for Financial Assets (LIFT)	**0**	0
Proceeds of disposal of assets held for sale (PPE)	**0**	9
Proceeds of disposal of assets held for sale (Intangible)	**0**	0
Proceeds from Disposal of Investment with DH	**0**	0
Proceeds from Disposal of Other Financial Assets	**0**	0
Proceeds from the disposal of Financial Assets (LIFT)	**0**	0
Loans Made in Respect of LIFT	**0**	0
Loans Repaid in Respect of LIFT	**0**	0
Rental Revenue	**0**	0
Net Cash Inflow/(Outflow) from Investing Activities	**(23,064)**	(15,759)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**981**	11,018
CASH FLOWS FROM FINANCING ACTIVITIES		
Public Dividend Capital Received	**1,409**	0
Public Dividend Capital Repaid	**0**	0
Loans received from DH - New Capital Investment Loans	**0**	0
Loans received from DH - New Revenue Support Loans	**0**	0
Other Loans Received	**0**	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal	**(2,000)**	(2,000)
Loans repaid to DH - Revenue Support Loans	**0**	0
Other Loans Repaid	**0**	0
Cash transferred to NHS Foundation Trusts	**0**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(1,081)**	(984)
Capital grants and other capital receipts (excluding donated / government granted cash receipts)	**0**	0
Net Cash Inflow/(Outflow) from Financing Activities	**(1,672)**	(2,984)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**(691)**	8,034
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**42,499**	34,465
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	**41,808**	42,499

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012-13 NHS Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCNE/SOCNI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS20 and similarly give rise to income and expenditure entries.

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the SOCNE/SOCNI.

1.4 Charitable Funds

For 2013-14, the divergence from the FReM that NHS Charitable Funds are not consolidated with NHS Trust's own returns is removed. Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. However, in accordance with IAS 1 (Presentation of Financial Statements) guidance on materiality, consolidation is not necessary. Charitable funds controlled by Sandwell & West Birmingham Hospitals NHS Trust are not considered material to the overall financial performance of the Trust and have therefore not been consolidated.

1.5 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is updated if the revision affects only that period or in the period of the update and future periods if the revision affects both current and future periods.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.6 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year

Provisions included in the financial position at 31st March 2014 are estimated using appropriate professional advice and based on circumstances prevailing at the balance sheet date.

1.7 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of the length of stay at the end of the reporting period compared to expected total length of stay.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. Sandwell & West Birmingham Hospitals NHS Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

The Trust undertakes limited sale of healthcare related goods, primarily drugs. Revenue in respect of these sales is initially recognised at the point of sale.

1.8 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Notes to the Accounts - 1. Accounting Policies (Continued)

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time Sandwell & West Birmingham Hospitals NHS Trust commits itself to the retirement, regardless of the method of payment.

1.9 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to Sandwell & West
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Notes to the Accounts - 1. Accounting Policies (Continued)

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

● Land and non-specialised buildings – market value for existing use
● Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

● the technical feasibility of completing the intangible asset so that it will be available for use
● the intention to complete the intangible asset and use it

Notes to the Accounts - 1. Accounting Policies (Continued)

● the ability to sell or use the intangible asset
● how the intangible asset will generate probable future economic benefits or service potential
● the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
● the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.12 Depreciation, amortisation and impairments
Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the [NHS body] expects to obtain economic benefits or service potential from the asset. This is specific to the [NHS body] and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives

At each reporting period end, Sandwell & West Birmingham Hospitals NHS Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.
AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.13 Donated assets
Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 Government grants
The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.15 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.16 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.17 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

Notes to the Accounts - 1. Accounting Policies (Continued)

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:
a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI Asset
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.19 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

1.20 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's approved discount rates.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.21 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 35.

1.22 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.23 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.24 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of Sandwell & West Birmingham Hospitals NHS Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.25 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Notes to the Accounts - 1. Accounting Policies (Continued)

Available for sale financial assets
Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at ‘fair value through profit and loss’ are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset’s carrying amount and the present value of the revised future cash flows discounted at the asset’s original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.26 Financial liabilities
Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial guarantee contract liabilities
Financial guarantee contract liabilities are subsequently measured at the higher of:

The premium received (or imputed) for entering into the guarantee less cumulative amortisation.

The amount of the obligation under the contract, as determined in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets.

Notes to the Accounts - 1. Accounting Policies (Continued)

Financial liabilities at fair value through profit and loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.27 Value Added Tax
Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.28 Foreign currencies
The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.29 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 44 to the accounts.

1.30 Public Dividend Capital (PDC) and PDC dividend
Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets, net assets transferred from NHS bodies dissolved on 1 April 2013 and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.31 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had Sandwell & West Birmingham Hospitals not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.32 Subsidiaries

Material entities over which Sandwell & West Birmingham Hospitals NHS Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with Sandwell & West Birmingham Hospitals NHS Trust or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

1.33 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCNE/SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.34 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2013-14. The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year:

IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation

2. Operating segments

The Board, as 'Chief Operating Decision Maker', has determined that the Trust operates in one material segment which is the provision of healthcare services. The segmental reporting format reflects the Trust's management and internal reporting structure.

The provision of healthcare (including medical treatment, research and education) is within one main geographical segment, the United Kingdom, and materially from Departments of HM Government in England.

Revenue from activities (medical treatment of patients) is analysed by customer type in Note 4 to the financial statements on Page 18. Other operating revenue is analysed in Note 5 to the financial statements on Page 18 and materially consists of revenues from healthcare research and development, medical education and the provision of services to other NHS bodies. Total revenue by individual customer within the whole of HM Government and considered material is disclosed in the related parties transactions Note 38 to the financial statements on Page 41.

The percentage of total revenue receivable in both 2013/14 and 2012/13 from within the whole of HM Government (primarily Primary Care Trusts and other NHS bodies) is 95% with 5% being received from elsewhere.

	SWB Hospitals		Other Segments		Total	
	2013-14	2012-13	**2013-14**	2012-13	**2013-14**	2012-13
	£000s	£000s	**£000s**	£000s	**£000s**	£000s
Income	**439,022**	433,007	**0**	0	**439,022**	433,007
Surplus/(Deficit)						
Segment surplus/(deficit)	**(2,505)**	(3,441)	**0**	0	**(2,505)**	(3,441)
Common costs	**0**	0	**0**	0	**0**	0
Surplus/(deficit) before interest	**436,517**	**429,566**	**0**	**0**	**436,517**	429,566
Net Assets:						
Segment net assets	**193,113**	183,385	**0**	0	**193,113**	183,385

3. Income generation activities

The Trust does not undertake any income generation activities where full cost exceeded £1m or was material to the financial performance of the Trust.

4. Revenue from patient care activities

	2013-14	2012-13
	£000s	£000s
NHS Trusts	**205**	50
NHS England	**798**	0
Clinical Commissioning Groups	**391,281**	0
Primary Care Trusts	**0**	385,823
Strategic Health Authorities	**0**	130
NHS Foundation Trusts	**1,175**	922
Department of Health	**0**	321
NHS Other (including Public Health England and Prop Co)	**0**	1,040
Non-NHS:		
Local Authorities	**0**	0
Private patients	**153**	116
Overseas patients (non-reciprocal)	**219**	500
Injury costs recovery	**1,523**	2,556
Other	**902**	417
Total Revenue from patient care activities	**396,256**	391,875

5. Other operating revenue

	2013-14	2012-13
	£000s	£000s
Recoveries in respect of employee benefits	**1,230**	1,554
Patient transport services	**251**	165
Education, training and research	**21,754**	20,866
Charitable and other contributions to revenue expenditure - NHS	**0**	77
Charitable and other contributions to revenue expenditure -non- NHS	**36**	0
Receipt of donations for capital acquisitions - NHS Charity	**213**	39
Receipt of Government grants for capital acquisitions	**0**	0
Non-patient care services to other bodies	**8,197**	7,444
Income generation	**4,002**	4,151
Rental revenue from finance leases	**0**	0
Rental revenue from operating leases	**0**	0
Other revenue	**7,083**	6,836
Total Other Operating Revenue	**42,766**	41,132
Total operating revenue	**439,022**	433,007

Other revenue includes £2,588,000 in respect of Estates and Facilities Service Level Agreements (£1,481,000 in 2012-13)

6. Revenue

Revenue is almost totally from the supply of services. Revenue from the sale of goods is not material.

7. Operating expenses

	2013-14 £000s	2012-13 £000s
Services from other NHS Trusts	**745**	213
Services from CCGs/NHS England	**91**	0
Services from other NHS bodies	**1,854**	0
Services from NHS Foundation Trusts	**4,975**	783
Services from Primary Care Trusts	0	2,860
Total Services from NHS bodies	**7,665**	3,856
Purchase of healthcare from non-NHS bodies	**1,476**	1,191
Trust Chair and Non-executive Directors	**66**	65
Supplies and services - clinical	**68,538**	65,861
Supplies and services - general	**6,005**	6,390
Consultancy services	**2,689**	3,472
Establishment	**4,903**	6,435
Transport	**1,161**	1,505
Premises	**17,330**	21,145
Hospitality	**0**	0
Insurance	**131**	0
Legal Fees	**321**	0
Impairments and Reversals of Receivables	**(22)**	191
Inventories write down	**151**	135
Depreciation	**13,404**	13,956
Amortisation	**269**	264
Impairments and reversals of property, plant and equipment	**8,922**	8,737
Impairments and reversals of intangible assets	**0**	0
Impairments and reversals of financial assets [by class]	**0**	0
Impairments and reversals of non current assets held for sale	**0**	0
Impairments and reversals of investment properties	0	0
Audit fees	**140**	146
Other auditor's remuneration [detail]	**12**	42
Clinical negligence	**7,221**	8,255
Research and development (excluding staff costs)	**246**	249
Education and Training	**1,145**	1,050
Change in Discount Rate	**123**	124
Other	**977**	1,277
Total Operating expenses (excluding employee benefits)	**142,873**	144,346
Employee Benefits		
Employee benefits excluding Board members	**290,428**	283,907
Board members	**1,161**	890
Total Employee Benefits	**291,589**	284,797
Total Operating Expenses	**434,462**	429,143

8. Operating Leases

The Trust does not hold a material value of operating leases as the majority of higher value leases are defined as finance leases. Residual operating leases relate to low value items of equipment.

8.1 Trust as lessee

	Land	Buildings	Other	2013-14 Total	2012-13
	£000s	£000s	£000s	£000s	£000s
Payments recognised as an expense					
Minimum lease payments				**93**	45
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**93**	45
Payable:					
No later than one year	13	0	80	**93**	18
Between one and five years	0	0	190	**190**	71
After five years	0	0	0	**0**	0
Total	**13**	**0**	**270**	**283**	89
Total future sublease payments expected to be received:				0	0

9. Employee benefits and staff numbers

9.1 Employee benefits

	2013-14 Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	**245,008**	220,668	24,340
Social security costs	**19,169**	18,389	780
Employer Contributions to NHS BSA - Pensions Division	**27,887**	27,008	879
Other pension costs	**0**	0	0
Termination benefits	**0**	0	0
Total employee benefits	**292,064**	**266,065**	**25,999**
Employee costs capitalised	**475**	475	0
Gross Employee Benefits excluding capitalised costs	**291,589**	**265,590**	**25,999**

Employee Benefits - Gross Expenditure 2012-13	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	240,182	221,834	18,348
Social security costs	19,259	18,585	674
Employer Contributions to NHS BSA - Pensions Division	25,891	25,516	375
Other pension costs	0	0	0
Termination benefits	0	0	0
TOTAL - including capitalised costs	285,332	265,935	19,397
Employee costs capitalised	535	535	0
Gross Employee Benefits excluding capitalised costs	284,797	265,400	19,397

In 2012-13 there were rows for 'other post-employment benefits' and 'other employment benefits'. These are now included within the 'Salaries and wages' row.

9.2 Staff Numbers

	2013-14 Total Number	Permanently employed Number	Other Number	2012-13 Total Number
Average Staff Numbers				
Medical and dental	**791**	742	49	790
Ambulance staff	**0**	0	0	0
Administration and estates	**1,518**	1,374	144	1,489
Healthcare assistants and other support staff	**1,494**	1,235	259	1,416
Nursing, midwifery and health visiting staff	**2,234**	1,988	246	2,162
Nursing, midwifery and health visiting learners	**0**	0	0	0
Scientific, therapeutic and technical staff	**1,141**	1,127	14	1,157
Social Care Staff	**0**	0	0	0
Other	**0**	0	0	0
TOTAL	**7,178**	**6,465**	**712**	7,013
Of the above - staff engaged on capital projects	**7**	7	0	9

9.3 Staff Sickness absence and ill health retirements

	2013-14 Number	2012-13 Number
Total Days Lost	64,130	64,353
Total Staff Years	6,526	6,575
Average working Days Lost	9.83	9.79

	2013-14 Number	2012-13 Number
Number of persons retired early on ill health grounds	**6**	7
	£000s	£000s
Total additional pensions liabilities accrued in the year	**488**	425

9.4 Exit Packages agreed in 2013-14

	2013-14			2012-13		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Less than £10,000	0	0	0	7	11	18
£10,000-£25,000	3	0	3	7	16	23
£25,001-£50,000	4	0	4	6	16	22
£50,001-£100,000	4	0	4	7	17	24
£100,001 - £150,000	2	0	2	2	3	5
£150,001 - £200,000	0	0	0	1	0	1
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost	**13**	**0**	**13**	30	63	93
Total resource cost (£000s)	**716**	**0**	**716**	1,233	2,505	3,738

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pension Scheme and Agenda for Change. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

9.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows.

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as “pension commutation”.

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

10. Better Payment Practice Code

10.1 Measure of compliance

	2013-14 Number	**2013-14 £000s**	2012-13 Number	2012-13 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**111,261**	**133,953**	99,086	109,335
Total Non-NHS Trade Invoices Paid Within Target	**102,542**	**124,099**	93,515	101,481
Percentage of NHS Trade Invoices Paid Within Target	**92.16%**	**92.64%**	94.38%	92.82%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,041**	**24,654**	2,160	**25,850**
Total NHS Trade Invoices Paid Within Target	**1,792**	**19,923**	1,217	**19,845**
Percentage of NHS Trade Invoices Paid Within Target	**87.80%**	**80.81%**	56.34%	76.77%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

10.2 The Late Payment of Commercial Debts (Interest) Act 1998

The Trust did not make any payments in respect of this act in 2013/14 or 2012/13.

11. Investment Revenue

	2013-14 £000s	2012-13 £000s
Interest revenue		
Bank interest	**129**	146
Total investment revenue	**129**	146

12. Other Gains and Losses

	2013-14 £000s	2012-13 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**(193)**	(139)
Total	**(193)**	(139)

13. Finance Costs

	2013-14 £000s	2012-13 £000s
Interest		
Interest on loans and overdrafts	**38**	55
Interest on obligations under finance leases	**40**	35
Interest on obligations under PFI contracts:		
- main finance cost	**1,488**	1,530
- contingent finance cost	**652**	452
Total interest expense	**2,218**	2,072
Other finance costs	**0**	10
Provisions - unwinding of discount	**66**	76
Total	**2,284**	2,158

14.1 Property, plant and equipment

2013-14	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2013	**37,132**	**151,136**	**898**	**0**	**99,416**	**3,697**	**22,926**	**1,718**	**316,923**
Transfers under Modified Absorption Accounting - PCTs & SHAs	**0**	**1,805**	**0**	**0**	**79**	**0**	**0**	**25**	**1,909**
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	0	0	0	0	**0**
Additions of Assets Under Construction	0	0	0	0	0	0	0	0	**0**
Additions Purchased	4,997	9,646	0	**0**	4,091	72	2,162	249	**21,217**
Additions Donated	0	0	0	0	213	0	0	0	**213**
Additions Government Granted	0	0	0	0	0	0	0	0	**0**
Additions Leased	0	0	0	**0**	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(4,303)	(57)	(27)	0	**(4,387)**
Revaluation	(7,261)	(6,856)	(13)	0	0	0	0	0	**(14,130)**
Impairments/negative indexation	(45)	(1,129)	0	0	0	0	0	0	**(1,174)**
Reversal of Impairments	2,087	6,447	69	0	0	0	0	0	**8,603**
Transfers to NHS Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	**0**
At 31 March 2014	**36,910**	**161,049**	**954**	**0**	**99,496**	**3,712**	**25,061**	**1,992**	**329,174**
Depreciation									
At 1 April 2013	**0**	**0**	**0**	**0**	**77,425**	**2,704**	**19,003**	**1,122**	**100,254**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(4,109)	(57)	(27)	0	**(4,193)**
Revaluation	(7,866)	(7,737)	(13)	0	0	0	0	0	**(15,616)**
Impairments	10,224	4,378	0	0	0	0	0	0	**14,602**
Reversal of Impairments	(2,358)	(3,295)	(27)	0	0	0	0	0	**(5,680)**
Charged During the Year	0	6,654	40	0	5,043	274	1,218	175	**13,404**
Transfers to NHS Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	**0**
At 31 March 2014	**0**	**0**	**0**	**0**	**78,359**	**2,921**	**20,194**	**1,297**	**102,771**
Net Book Value at 31 March 2014	**36,910**	**161,049**	**954**	**0**	**21,137**	**791**	**4,867**	**695**	**226,403**
Asset financing:									
Owned - Purchased	36,910	139,525	954	0	20,070	766	4,852	695	**203,772**
Owned - Donated	0	401	0	0	1,021	0	15	0	**1,437**
Owned - Government Granted	0	966	0	0	0	0	0	0	**966**
Held on finance lease	0	0	0	0	46	25	0	0	**71**
On-SOFP PFI contracts	0	20,157	0	0	0	0	0	0	**20,157**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2014	**36,910**	**161,049**	**954**	**0**	**21,137**	**791**	**4,867**	**695**	**226,403**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2013	15,306	18,504	377	0	158	0	0	11	**34,356**
Movements	2,647	4,937	54	0	(87)	0	0	(8)	**7,543**
At 31 March 2014	**17,953**	**23,441**	**431**	**0**	**71**	**0**	**0**	**3**	**41,899**

As the Trust's land and buildings were subject to a full professional valuation at 31st March 2014, depreciation totals included in the above schedule will be netted off with the effect that the balances at 1st April 2014 will reflect only that net value and not gross value and depreciation.

14.2 Property, plant and equipment prior-year

2012-13	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:									
At 1 April 2012	35,798	163,387	990	0	98,251	3,623	21,317	1,463	324,829
Additions - Assets Under Construction	0	0	0	0	0	0	0	0	0
Additions - purchased	1,615	8,849	13	0	4,864	263	1,609	255	17,468
Additions - donated	0	0	0	0	39	0	0	0	39
Additions - government granted	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	(16,336)	(81)	0	(3,738)	(189)	0	0	(20,344)
Revaluation & indexation gains	523	57	0	0	0	0	0	0	580
Impairments	(804)	(5,271)	(24)	0	0	0	0	0	(6,099)
Reversals of impairments	0	450	0	0	0	0	0	0	450
Transfer to NHS Foundation Trust	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under absorption accounting	0	0	0	0	0	0	0	0	0
At 31 March 2013	**37,132**	**151,136**	**898**	**0**	**99,416**	**3,697**	**22,926**	**1,718**	**316,923**
Depreciation									
At 1 April 2012	0	0	0	0	76,208	2,647	17,912	990	97,757
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	(16,336)	(81)	0	(3,590)	(189)	0	0	(20,196)
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	0
Impairments	0	9,613	35	0	0	0	0	0	9,648
Reversal of Impairments	0	(910)	(1)	0	0	0	0	0	(911)
Charged During the Year	0	7,633	47	0	4,807	246	1,091	132	13,956
Transfer to NHS Foundation Trust	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under absorption accounting	0	0	0	0	0	0	0	0	0
At 31 March 2013	**0**	**0**	**0**	**0**	**77,425**	**2,704**	**19,003**	**1,122**	**100,254**
Net book value at 31 March 2013	**37,132**	**151,136**	**898**	**0**	**21,991**	**993**	**3,923**	**596**	**216,669**
Purchased									0
Donated									0
Government Granted									0
Total at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Asset financing:									
Owned	37,132	132,084	898	0	21,863	884	3,923	596	197,380
Held on finance lease	0	0	0	0	128	109	0	0	237
On-SOFP PFI contracts	0	19,052	0	0	0	0	0	0	19,052
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	**37,132**	**151,136**	**898**	**0**	**21,991**	**993**	**3,923**	**596**	**216,669**

14.3 (cont). Property, plant and equipment

The Trust received donated assets to the value of £213,000 during the year, £201,000 via Sandwell And West Birmingham Hospital's charitable funds and £12,000 from the League of Friends, both in respect of medical equipment.

The Trust's property assets (land and buildings) were revalued during the year by the District Valuation Service and using Modern Equivalent Asset valuation techniques with a valuation date of 31st March 2014. Valuation was undertaken with reference to the size, location and function of existing buildings and the basis on which they would be replaced by Modern Equivalent Assets.

Asset lives for currently held assets are as follows:

Buildings excluding dwellings 4-76 years
Dwellings 6-41 years
Plant and machinery 0-11 years
Transport equipment 0-7 years
Information technology 0-5 years
Furniture and fittings 0-10 years

15.1 Intangible non-current assets

2013-14	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2013	**0**	**2,691**	**0**	**164**	**0**	**2,855**
Transfers under Modified Absorption Accounting - PCTs & SHAs	**0**	**0**	**0**	**0**	**0**	**0**
Transfers under Modified Absorption Accounting - Other Bodies	**0**	**0**	**0**	**0**	**0**	**0**
Additions - purchased	0	210	0	21	0	**231**
Additions - internally generated	0	0	0	0	0	**0**
Additions - donated	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	**0**
Additions - leased	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as Held for Sale and Reversals	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments charged to reserves	0	0	0	0	0	**0**
Reversal of impairments charged to reserves	0	0	0	0	0	**0**
Transfer to NHS Foundation Trust	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	**0**
At 31 March 2014	**0**	**2,901**	**0**	**185**	**0**	**3,086**
Amortisation						
At 1 April 2013	**0**	**1,931**	**0**	**0**	**0**	**1,931**
Reclassifications	0	0	0	0	0	**0**
Reclassified as Held for Sale and Reversals	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	0	269	0	0	0	**269**
Transfer to NHS Foundation Trust	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	**0**
At 31 March 2014	**0**	**2,200**	**0**	**0**	**0**	**2,200**
Net Book Value at 31 March 2014	**0**	**701**	**0**	**185**	**0**	**886**
Asset Financing: Net book value at 31 March 2014 comprises:						
Purchased	0	699	0	185	0	**884**
Donated	0	2	0	0	0	**2**
Government Granted	0	0	0	0	0	**0**
Finance Leased	0	0	0	0	0	**0**
On-balance Sheet PFIs	0	0	0	0	0	**0**
Total at 31 March 2014	**0**	**701**	**0**	**185**	**0**	**886**

Revaluation reserve balance for intangible non-current assets

	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2013	0	0	0	0	0	**0**
Movements (specify)	0	0	0	0	0	**0**
At 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**

15.2 Intangible non-current assets prior year

2012-13	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:						
At 1 April 2012	0	2,481	0	261	0	2,742
Additions - purchased	0	210	0	0	0	210
Additions - internally generated	0	0	0	0	0	0
Additions - donated	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	(97)	0	(97)
Revaluation & indexation gains	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Transfer to NHS Foundation Trust	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2013	0	2,691	0	164	0	2,855
Amortisation						
At 1 April 2012	0	1,667	0	0	0	1,667
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation or indexation gains	0	0	0	0	0	0
Impairments charged to operating expenses	0	0	0	0	0	0
Reversal of impairments charged to operating expenses	0	0	0	0	0	0
Charged during the year	0	264	0	0	0	264
Transfer to NHS Foundation Trust	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2013	0	1,931	0	0	0	1,931
Net book value at 31 March 2013	0	760	0	164	0	924
Net book value at 31 March 2013 comprises:						
Purchased		757		164		921
Donated		3				3
Government Granted						0
Total at 31 March 2013	0	760	0	164	0	924

15.3 Intangible non-current assets

Asset lives for intangible assets (purchased computer software) range from 0 to 5 years. Assets are initially recognised at cost and amortised over the expected life of the asset. They have not been revalued.

An intangible asset in respect of Carbon Emission Credits is included in the Trust's accounts to reflect the receipt and consumption of these credits. They are valued at market price at 31st March 2014.

The Trust does not hold any revaluation reserve balances in respect of intangible assets.

16. Analysis of impairments and reversals recognised in 2013-14

	2013-14 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	8,922
Total charged to Annually Managed Expenditure	**8,922**
Total Impairments of Property, Plant and Equipment charged to SoCI	**8,922**
Intangible assets impairments and reversals charged to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	**0**
Total Impairments of Intangibles charged to SoCI	**0**
Financial Assets charged to SoCI	
Loss or damage resulting from normal operations	0
Total charged to Departmental Expenditure Limit	**0**
Loss as a result of catastrophe	0
Other	0
Total charged to Annually Managed Expenditure	**0**
Total Impairments of Financial Assets charged to SoCI	**0**
Non-current assets held for sale - impairments and reversals charged to SoCI.	
Loss or damage resulting from normal operations	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	**0**
Total impairments of non-current assets held for sale charged to SoCI	**0**
Total Impairments charged to SoCI - DEL	**0**
Total Impairments charged to SoCI - AME	**8,922**
Overall Total Impairments	**8,922**
Donated and Gov Granted Assets, included above	
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0

All valuations of land and buildings were carried out on behalf of the Trust at 31st March 2014 by the District Valuations Service (DVS). Revaluation of assets, impairment and reversal of impairments are based on the professional valuation by the DVS.

16. Analysis of impairments and reversals recognised in 2013-14

	Total	Property Plant and Equipment	Intangible Assets	Financial Assets	Non-Current Assets Held for Sale
	£000s	£000s	£000s	£000s	£000s
Impairments and reversals taken to SoCI					
Loss or damage resulting from normal operations	**0**	0	0	0	0
Over-specification of assets	**0**	0	0	0	0
Abandonment of assets in the course of construction	**0**	0	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**	**0**	**0**
Unforeseen obsolescence	**0**	0	0	0	0
Loss as a result of catastrophe	**0**	0	0	0	0
Other	**0**	0	0	0	0
Changes in market price	**8,922**	8,922	0	0	0
Total charged to Annually Managed Expenditure	**8,922**	**8,922**	**0**	**0**	**0**
Total Impairments of Property, Plant and Equipment charged to SoCI	**8,922**	**8,922**	**0**	**0**	**0**

Donated and Gov Granted Assets, included above	**£000s**
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**

17. Investment property

The Trust did not hold any investment property in 2013-14 or in 2012-13.

18. Commitments

18.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2014 £000s	31 March 2013 £000s
Property, plant and equipment	**1,128**	4,128
Intangible assets	**0**	0
Total	**1,128**	4,128

18.2 Other financial commitments

The trust has not entered into any non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements).

19. Intra-Government and other balances

	Current receivables £000s	**Non-current receivables £000s**	**Current payables £000s**	**Non-current payables £000s**
Balances with other Central Government Bodies	8,254	0	14,218	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	2,829	0	2,088	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	0	0	0	0
At 31 March 2014	**11,083**	**0**	**16,306**	**0**
prior period:				
Balances with other Central Government Bodies	3,766	0	5,055	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	33	0	0	0
Balances with NHS Trusts and Foundation Trusts	2,439	0	1,130	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	0	0	0	0
At 31 March 2013	**6,238**	**0**	**6,185**	**0**

20. Inventories

	Drugs £000s	Consumables £000s	Work in Progress £000s	Energy £000s	Loan Equipment £000s	Other £000s	Total £000s	Of which held at NRV £000s
Balance at 1 April 2013	**1,705**	**1,649**	**0**	**250**	**0**	**0**	**3,604**	0
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0	0	0	0	0		0
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	0	0		0
Additions	30,786	3,905	0	0	0	0	**34,691**	0
Inventories recognised as an expense in the period	(30,848)	(4,006)	0	(18)	0	0	**(34,872)**	0
Write-down of inventories (including losses)	(140)	(11)	0	0	0	0	**(151)**	0
Reversal of write-down previously taken to SOCI	0	0	0	0	0	0	**0**	0
Transfers (to) Foundation Trusts	0	0	0	0	0	0	**0**	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	**0**	0
Balance at 31 March 2014	**1,503**	**1,537**	**0**	**232**	**0**	**0**	**3,272**	**0**

[If reversal of inventory expense, describe circumstances].
Any non-current inventories should be disclosed.

21.1 Trade and other receivables

	Current		Non-current	
	31 March 2014 £000s	31 March 2013 £000s	**31 March 2014 £000s**	31 March 2013 £000s
NHS receivables - revenue	**11,083**	6,099	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**514**	120	**0**	0
Non-NHS receivables - revenue	**2,198**	1,819	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**2,020**	524	**0**	0
Provision for the impairment of receivables	**(1,578)**	(1,640)	**(285)**	(398)
VAT	**657**	575	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**2,554**	2,949	**1,296**	1,446
Total	**17,448**	10,446	**1,011**	1,048
Total current and non current	**18,459**	11,494		
Included in NHS receivables are prepaid pension contributions:	**0**			

The great majority of trade is with NHS Clinical Commissioning Groups (CCGs). As CCGs are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

There are no material individual receivables which are neither past due nor impaired.

For 2013/14, PDC dividends payable to the Department of Health were overpaid and balances due to Sandwell & West Birmingham Hospitals are as follows:

PDC dividend: balance receivable/(payable) at 31 March 2014	(50)
PDC dividend: balance receivable/(payable) at 31 March 2013	440

21.2 Receivables past their due date but not impaired

	31 March 2014 £000s	31 March 2013 £000s
By up to three months	**1,001**	109
By three to six months	**537**	202
By more than six months	**285**	68
Total	**1,823**	379

21.3 Provision for impairment of receivables

	2013-14 £000s	2012-13 £000s
Balance at 1 April 2013	**(2,038)**	(1,995)
Transfers under Modified Absorption Accounting - PCTs & SHAs	**0**	0
Transfers under Modified Absorption Accounting - Other Bodies	**0**	0
Amount written off during the year	**153**	148
Amount recovered during the year	**321**	602
(Increase)/decrease in receivables impaired	**(299)**	(793)
Transfer to NHS Foundation Trust	**0**	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	0
Balance at 31 March 2014	**(1,863)**	**(2,038)**

Impairment of receivables is based on an assessment of individual amounts receivable taking into account the age of the debt and other known circumstances regarding the debt or the debtor.

22. Other Financial Assets - Current/Non Current

The Trust does not hold any other financial assets.

23. Other current assets

The Trust does not hold any other current assets.

24. Cash and Cash Equivalents

	31 March 2014	31 March 2013
	£000s	£000s
Opening balance	**42,499**	34,465
Net change in year	**(691)**	8,034
Closing balance	**41,808**	42,499
Made up of		
Cash with Government Banking Service	**41,781**	42,467
Commercial banks	**0**	32
Cash in hand	**27**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**41,808**	42,499
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**41,808**	42,499
Patients' money held by the Trust, not included above	**0**	0

25. Non-current assets held for sale

The Trust does not hold any non current assets for sale.

26. Trade and other payables

	Current		Non-current	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000s	£000s	**£000s**	£000s
NHS payables - revenue	**8,767**	6,185	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**1,756**	0	**0**	0
Non-NHS payables - revenue	**11,330**	17,366	**0**	0
Non-NHS payables - capital	**6,220**	7,967	**0**	0
Non-NHS accruals and deferred income	**20,664**	11,142	**0**	0
Social security costs	**2,865**	50	**0**	**0**
VAT	**1**	0	**0**	0
Tax	**2,918**	35	**0**	**0**
Payments received on account	**0**	0	**0**	0
Other	**617**	360	**0**	0
Total	**55,138**	43,105	**0**	0
Total payables (current and non-current)	**55,138**	**43,105**		

Included above:		
to Buy Out the Liability for Early Retirements Over 5 Years	**0**	0
outstanding Pension Contributions at the year end	**3,763**	3,371

27. Other liabilities

The Trust does not hold any other liabilities.

28. Borrowings

	Current		Non-current	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000s	£000s	**£000s**	£000s
Bank overdraft - Government Banking Service	**0**	0	**0**	0
Bank overdraft - commercial banks	**0**	0	**0**	0
Loans from Department of Health	**2,000**	2,000	**1,000**	3,000
Loans from other entities	**0**	0	**0**	0
PFI liabilities:				
Main liability	**998**	1,029	**27,915**	28,913
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**66**	182	**0**	53
Other (describe)	**0**	0	**0**	0
Total	**3,064**	**3,211**	**28,915**	**31,966**
Total other liabilities (current and non-current)	**31,979**	**35,177**		

Loans - repayment of principal falling due in:

	31 March 2014		
	DH	**Other**	**Total**
	£000s	**£000s**	**£000s**
0-1 Years	2,000	1,065	**3,065**
1 - 2 Years	1,000	2,323	**3,323**
2 - 5 Years	0	2,120	**2,120**
Over 5 Years	0	23,471	**23,471**
TOTAL	**3,000**	**28,979**	**31,979**

29. Other financial liabilities

The Trust does not hold any other financial liabilities.

30. Deferred revenue

	Current		Non-current	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000s	£000s	**£000s**	£000s
Opening balance at 1 April 2013	**2,118**	3,284	**0**	0
Deferred revenue addition	**4,138**	1,822	**0**	0
Transfer of deferred revenue	**(2,118)**	(2,988)	**0**	0
Current deferred Income at 31 March 2014	**4,138**	2,118	**0**	0
Total deferred income (current and non-current)	**4,138**	2,118		

31. Finance lease obligations as lessee

The only material finance lease held by the Trust relates to the Birmingham Treatment Centre which was funded under the Private Finance Initiative. Other finance lease are short term, generally five years or less, and relate to items of medical equipment or vehicles.

Contingent rentals are calculated only for the Birmingham Treatment Centre and are derived by considering the variation in payments between the base value and the value uplifted to reflect general price changes which is the basis on which lease rentals are chargeable.

Future minimum lease payments are discounted using Treasury approved discount rates to generate the present value of lease payments.

Amounts payable under finance leases (Other)	**Minimum lease payments**		**Present value of minimum**	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000s	£000s	**£000s**	£000s
Within one year	**66**	182	**66**	182
Between one and five years	**0**	53	**0**	53
After five years	**0**	0	**0**	0
Less future finance charges	0	0	**0**	0
Minimum Lease Payments / Present value of minimum lease payments	**66**	235	**66**	235
Included in:				
Current borrowings			**66**	182
Non-current borrowings			**0**	53
			66	235

32. Provisions

Comprising:

	Total	Early Departure Costs	Legal Claims	Restructuring	Continuing Care	Equal Pay (incl. Agenda for Change	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2013	**13,523**	846	337	4,395	0	8	7,937	0
Transfers under Modified Absorption Accounting - PCTs & SHAs	**0**	0	0	0	0	0	0	0
Transfers under Modified Absorption Accounting - Other Bodies	**0**	0	0	0	0	0	0	0
Arising During the Year	**7,910**	0	429	2,481	0	0	5,000	0
Utilised During the Year	**(5,643)**	(93)	(245)	(758)	0	0	(4,547)	0
Reversed Unused	**(5,381)**	(9)	(165)	(3,637)	0	(8)	(1,562)	0
Unwinding of Discount	**66**	20	0	0	0	0	46	0
Change in Discount Rate	**123**	16	0	0	0	0	107	0
Transfers to NHS Foundation Trusts (for Trusts becoming FTs only)	**0**	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	0	0	0	0	0	0	0
Balance at 31 March 2014	**10,598**	**780**	**356**	**2,481**	**0**	**0**	**6,981**	**0**
Expected Timing of Cash Flows:								
No Later than One Year	**8,036**	93	356	2,481	0	0	5,106	0
Later than One Year and not later than Five Years	**989**	439	0	0	0	0	550	0
Later than Five Years	**1,573**	248	0	0	0	0	1,325	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2014	59,553
As at 31 March 2013	60,295

Provisions relating to other staff covers pre 1995 early retirement costs. Liabilities and the timing of liabilities are based on pensions provided to individual ex employees and projected life expectancies using government actuarial tables. The major uncertainties rest around life expectancies assumed for the cases.

Legal claims cover the Trust's potential liabilities for public and employer liability. Potential liabilities are calculated using professional assessment of individual cases by the Trust's insurers. The Trust's maximum liability for any individual case is £10,000 with the remainder being covered by insurers.

Other provisions cover Injury Benefits £1,992,000, employment tribunals and litigation claims £387,000, other contractual obligations £4,391,000 and £211,000 for carbon emission credits repayable.

Injury benefit provisions are calculated with reference to the NHS Pensions Agency and actuarial tables for life expectancy.

Staff litigation claims represent potential liabilities to the Trust in respect of claims made by current or former employees.

The timing and amount of the cashflows is shown above but it must be pointed out that, in the case of provisions, there will always be a measure of uncertainty. However, the values listed are best estimates taking all the relevant information and professional advice into consideration.

33. Contingencies

	31 March 2014 £000s	31 March 2013 £000s
Contingent liabilities		
Equal Pay	**0**	0
Other	**(620)**	(794)
Amounts Recoverable Against Contingent Liabilities	**0**	0
Net Value of Contingent Liabilities	**(620)**	(794)

The Trust does not hold any contingent assets.

Contingent liabilities held by the Trust relate to employers and public liability claims (£180,000) and injury benefits (£440,000). These values relate to the difference between the maximum potential value of claims and the amount included by the Trust as a provision based on professional notification of the likelihood of the success of claims.

34. PFI and LIFT - additional information

The information below is required by the Department of Heath for inclusion in national statutory accounts

Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI	**2013-14 £000s**	2012-13 £000s
Total charge to operating expenses in year - OFF SOFP PFI	**0**	0
Service element of on SOFP PFI charged to operating expenses in year	**973**	1,362
Total	973	1,362
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	**1,244**	1,091
Later than One Year, No Later than Five Years	**5,415**	5,201
Later than Five Years	**34,764**	35,502
Total	**41,423**	41,794

The estimated annual payments in future years are not expected to be materially different from those which the Trust is committed to make during the next year.

Imputed "finance lease" obligations for on SOFP PFI contracts due	**2013-14 £000s**	2012-13 £000s
No Later than One Year	**3,148**	3,120
Later than One Year, No Later than Five Years	**13,281**	12,722
Later than Five Years	**63,394**	65,712
Subtotal	**79,823**	81,554
Less: Interest Element	**(50,910)**	(51,612)
Total	**28,913**	29,942

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due	**2013-14**	2012-13
Analysed by when PFI payments are due	**£000s**	£000s
No Later than One Year	**3,148**	2,872
Later than One Year, No Later than Five Years	**12,469**	12,159
Later than Five Years	**41,222**	**42,507**
Total	**56,839**	**57,538**

Number of on SOFP PFI Contracts		
Total Number of on PFI contracts	**1**	
Number of on PFI contracts which individually have a total commitments value in excess of £500m	**0**	

35. Impact of IFRS treatment - current year

The information below is required by the Department of Heath for budget reconciliation purposes

	2013-14 £000s	2012-13 £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)		
Depreciation charges	**518**	545
Interest Expense	**2,140**	1,982
Impairment charge - AME	**(1,108)**	0
Impairment charge - DEL	**0**	882
Other Expenditure	**973**	1,362
Revenue Receivable from subleasing	**0**	0
Impact on PDC dividend payable	**(419)**	(434)
Total IFRS Expenditure (IFRIC12)	**2,104**	**4,337**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)	**(3,950)**	(3,891)
Net IFRS change (IFRIC12)	**(1,846)**	**446**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12		
Capital expenditure 2013-14	**0**	0
UK GAAP capital expenditure 2013-14 (Reversionary Interest)	**192**	186

36. Financial Instruments

36.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS trust has with commissioners and the way those commissioners are financed, the NHS trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The trust has no overseas operations. The trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2014 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical commissioning Groups, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

36.2 Financial Assets

	At 'fair value through profit and loss' £000s	Loans and receivables £000s	Available for sale £000s	Total £000s
Embedded derivatives	0	0	0	**0**
Receivables - NHS	0	10,290	0	**10,290**
Receivables - non-NHS	0	6,241	0	**6,241**
Cash at bank and in hand	0	41,808	0	**41,808**
Other financial assets	0	0	0	**0**
Total at 31 March 2014	**0**	**58,339**	**0**	**58,339**
Embedded derivatives	0	0	0	0
Receivables - NHS	0	6,219	0	6,219
Receivables - non-NHS	0	5,275	0	5,275
Cash at bank and in hand	0	42,499	0	42,499
Other financial assets	0	0	0	0
Total at 31 March 2013	0	53,993	0	53,993

36.3 Financial Liabilities

	At 'fair value through profit and loss' £000s	Other £000s	Total £000s
Embedded derivatives	0	0	**0**
NHS payables	0	6,636	**6,636**
Non-NHS payables	0	44,312	**44,312**
Other borrowings	0	0	**0**
PFI & finance lease obligations	0	28,979	**28,979**
Other financial liabilities	0	0	**0**
Total at 31 March 2014	**0**	**79,927**	**79,927**
Embedded derivatives	0	0	0
NHS payables	0	6,185	6,185
Non-NHS payables	0	26,920	26,920
Other borrowings	0	0	0
PFI & finance lease obligations	0	29,994	29,994
Other financial liabilities	0	0	0
Total at 31 March 2013	0	63,099	63,099

PFI & finance lease obligations relate to amounts payable in respect of the Trust's PFI and finance lease funded assets over the remaining life of the

37. Events after the end of the reporting period

There are no material events after the reporting period which may have a material impact on the Trust's reported financial performance.

38. Related party transactions

During the year none of the Department of Health Ministers, trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Sandwell & West Birmingham Hospitals NHS Trust.

The Department of Health is regarded as a related party. During 2013/2014, Sandwell And West Birmingham Hospitals NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
NHS Sandwell & West Birmingham CCG	8	253,266	4	3,454
NHS Cross City CCG		44,240	162	
NHS Birmingham South & Central CCG		13,555		197
NHS Walsall CCG		5,276		131
NHS Litigation Authority	7,221		7	
NHS Business Services Authority (NHS Pensions)	27,887		3,763	

There are a number of other Health Bodies with which the Trust has transacted during the normal course of its activities but these are not considered to be material.

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with the Department for Education and Skills in respect of university hospitals and Sandwell MBC and Birmingham City Council in respect of joint enterprises.

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the Trustees for which are also members of the NHS Trust Board.

The Trust has ongoing contractual relationships with all of the entities listed above.

39. Losses and special payments

The total number of losses cases in 2013-14 and their total value was as follows:

	Total Value of Cases	**Total Number of Cases**
	£s	
Losses	284,559	222
Special payments	250,521	88
Total losses and special payments	535,080	310

The total number of losses cases in 2012-13 and their total value was as follows:

	Total Value of Cases	**Total Number of Cases**
	£s	
Losses	221,818	310
Special payments	199,044	87
Total losses and special payments	420,862	397

There were no individual cases where the value of losses or special payments exceeded £250,000 in either 2013/201 or 2012/2013.

40. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

40.1 Breakeven performance

	2005-06 £000s	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s
Turnover	313,388	327,536	348,475	359,161	384,774	387,870	424,144	433,007	**439,022**
Retained surplus/(deficit) for the year	(5,726)	3,399	6,524	2,547	(28,646)	(6,885)	4,540	(3,441)	**(2,505)**
Adjustment for:									
Timing/non-cash impacting distortions:									
Pre FDL(97)24 Agreements	0	0	0	0	0	0	0	0	**0**
2006/07 PPA (relating to 1997/98 to 2005/06)	0	0	0	0	0	0	0	0	0
2007/08 PPA (relating to 1997/98 to 2006/07)	0	0	0	0	0	0	0	0	0
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	0	0	0	0	0	0	0
Adjustments for Impairments	0	0	0	0	36,463	9,533	(2,395)	8,872	**8,922**
Adjustments for impact of policy change re donated/government grants assets	0	0	0	0	0	0	358	1,092	**334**
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*	0	0	0	0	(557)	(455)	(640)	0	**0**
Adsorption Accounting Adjustment	0	0	0	0	0	0	0	0	**0**
Other agreed adjustments	0	5,726	0	0	0	0	0	**0**	**0**
Break-even in-year position	**(5,726)**	**9,125**	**6,524**	**2,547**	**7,260**	**2,193**	**1,863**	**6,523**	**6,751**
Break-even cumulative position	**(13,527)**	**(4,402)**	**2,122**	**4,669**	**11,929**	**14,122**	**15,985**	**22,508**	**29,259**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS [organisation]'s financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2005-06 %	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %
Materiality test (I.e. is it equal to or less than 0.5%):									
Break-even in-year position as a percentage of turnover	-1.83	2.79	1.87	0.71	1.89	0.57	0.44	1.51	1.54
Break-even cumulative position as a percentage of turnover	-4.32	-1.34	0.61	1.30	3.10	3.64	3.77	5.20	6.66

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

40.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

40.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2013-14	2012-13
	£000s	£000s
External financing limit (EFL)	**3,015**	5,425
Cash flow financing	**(981)**	(11,018)
Unwinding of Discount Adjustment	**66**	0
Finance leases taken out in the year	**0**	0
Other capital receipts	**0**	0
Net external financing requirement	**(915)**	(11,018)
Under/(Over) Spend against EFL	**3,930**	16,443

40.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2013-14	2012-13
	£000s	£000s
Gross capital expenditure	**21,630**	17,717
Less: book value of assets disposed of	**(193)**	(245)
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(213)**	(39)
Charge against the capital resource limit	**21,224**	17,433
Capital resource limit	**21,815**	21,498
(Over)/underspend against the capital resource limit	**591**	4,065

41. Third party assets

The Trust does hold small amounts of cash and cash equivalents which relate to monies held by the NHS Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts. However, for both 31st March 2014 and 31st March 2013 the balance was nil.

42. Charitable Funds

The Board of Sandwell & West Birmingham Hospitals acts as corporate trustee for the Sandwell & West Birmingham Hospitals NHS Trust Charitable Funds. Within the specifications of IAS1, these funds are not considered to be material to the overall financial performance or position of the Trust and are therefore not consolidated into the accounts of the Trust.

For the financial year ended 31st March 2014, key performance statistics for the Charitable Funds are as follows:

	31st March 2014 £000	31st March 2013 £000
Incoming Resources	1,548	1,275
Resources Expended	(1,049)	(858)
Other Movements	(9)	265
Net Movement in Funds	490	682
Total Value of Charitable Funds at Year End	5,797	5,307

Sandwell and West Birmingham Hospitals NHS Trust

ISA 260 Audit Highlights Memorandum

2013/14

5 June 2014

Contents

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This report is addressed to Sandwell and West Birmingham Hospitals NHS Trust (the Trust) and has been prepared for the sole use of the Trust. We take no responsibility to any member of staff acting in their individual capacities, or to third parties. The Audit Commission has issued a document entitled Statement of Responsibilities of Auditors and Audited Bodies. This summarises where the responsibilities of auditors begin and end and what is expected from the audited body. We draw your attention to this document.

External auditors do not act as a substitute for the audited body's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

If you have any concerns or are dissatisfied with any part of KPMG's work, in the first instance you should contact Andrew Bostock who is the engagement lead to the Trust or Trevor Rees (0161 246 4063 / trevor.rees@kpmg.co.uk), the national contact partner for all of KPMG's work with the Audit Commission. After this, if you are still dissatisfied with how your complaint has been handled you can access the Audit Commission's complaints procedure. You can contact the Complaints Unit by phone (0303 444 8330), by email (complaints@audit-commission.gsi.gov.uk), through the Audit Commission website (www.audit-commission.gov.uk/about-us/contact-us)by textphone/minicom (0207 630 0421), or via post to The Private Secretary, Controller of Audit's Office, Audit Commission, 3rd Floor Fry Building, 2 Marsham Street, London, SW1P 4DF.

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Introduction

Background

The Audit Commission's Code of Audit Practice (the Code) requires us to report on the work we have carried out to discharge our statutory audit responsibilities together with any governance issues identified. We report these areas to those charged with governance (in this case the Audit Committee) at the time you are considering the financial statements. International Standard on Auditing (ISA) 260 requires us to provide a summary of the work we have carried out to discharge our statutory audit responsibilities to those charged with governance at the time they are considering the financial statements. ISA 260 requires that we consider the audit matters detailed in Appendix C and we do this by exception through this report. We are also required to communicate with those charged with governance significant matters arising during the audit in connection with the entity's related parties. This report summarises the key issues we have identified during our audit of the financial statements and will be presented to the Audit Committee on 5 June 2014.

As auditors we have a responsibility for forming and expressing an opinion on the financial statements that have been prepared by management with the oversight of those charged with governance. The audit of the financial statements does not relieve management, those charged with management or those charged with governance of their responsibilities.

Use of Resources (UoR)	Sandwell and West Birmingham Hospitals NHS Trust ('the Trust') is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources and regularly reviewing the adequacy and effectiveness of these arrangements. Our responsibility is to satisfy ourselves that you have proper arrangements in place by reviewing and examining evidence relevant to your corporate performance management and financial management arrangements and reporting on these arrangements. We reflect our judgements from the use of resources work in the value for money (VfM) conclusion. Our conclusion provides assurance on the trust's arrangements for achieving economy, efficiency and effectiveness in its use of resources. The Trust is responsible for putting in place systems of internal control to ensure the regularity and lawfulness of transactions, to maintain proper accounting records and to prepare financial statements that give a true and fair view of its financial position and its expenditure and income. It must also publish an Annual Governance Statement (AGS) with its Annual Report.
Accounts	We audit the financial statements and provide our opinion as to whether they give a true and fair view of your financial position and expenditure and income, and whether they have been prepared in accordance with the relevant accounting policies directed by the Secretary of State.

Structure of report

This report is structured as follows:

- Section 2 summarises the headline messages.
- Section 3 outlines our findings and final conclusions on the UoR work.
- Section 4 sets out our findings on the audit of the accounts.

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Headlines

The table below summarises the work we have completed throughout the year and the results of the audit.

Use of Resources and audit certification	■ Based on the findings of our work, we concluded that the Trust has adequate arrangements to secure economy, efficiency and effectiveness in its use of resources. ■ We are required to certify that we have completed the audit of the Trust financial statements in accordance with the requirements of the Code. If there are any circumstances under which we cannot issue a certificate, then we must report this to those charged with governance. There are no issues that would cause us to delay the issue of our certificate of completion of the audit.
Accounts, unadjusted audit differences and management representations	■ We intend to issue an unqualified audit opinion on the accounts following the Trust Board adopting the accounts and receipt of the management representation letter and the completion of our final quality procedures. ■ We have completed our audit of the financial statements. The finance team supported the early resolution of risks identified in our *External Audit Plan 2013/14*, having previously presented an update to the Audit Committee in January 2014 ahead of the final resolution that was presented in April 2014. – Our audit work did not identify any material misstatements. There are two unadjusted misstatements totalling £5.1 million in respect of balances the Trust has in respect of Right Care, Right Here and other future programme monies that have been treated as provisions as opposed to deferred income. These are outlined in Appendix C. There is no impact on the Trust's reported position. – We have agreed presentational changes to the accounts with Finance, mainly related to compliance with relevant guidance. – In addition to our routine request we have requested management representations over the accounting treatment of monies relating to the Right Care, Right Here programme and other income received from Commissioners relating to long term programmes. Section four provides further details. ■ We have also reviewed the Trust's Annual Governance Statement (AGS) and Remuneration Report. We have subsequently completed our final checks on the remuneration report to reflect the changes made as the draft did not include the new requirements in relation to pension benefits, for which guidance was released later in the year. ■ We have not yet read the content of the Annual Report in detail. We were provided with a draft copy of the Trust's Annual Report on 23 May 2014 which contained a number of omissions and was not fully compliant with the revised 2013/2014 guidance, most significantly the requirement to signpost a separate Strategic Report which we are required to refer to in our opinion.
Recommendations	■ We have made six recommendations as a result of our 2013/14 audit work. The key recommendations are: – **Resilience and capacity of the Finance Team –** As a result of some functions being dependent upon key individuals, and knowledge not shared within the wider team, the Trust should review the roles and responsibilities of the finance team and benchmark to best practice and other similar sized Trusts. This will offer the Trust more resilience in the absence or departure staff and present development opportunities for staff. – **Aligning the production of the Annual Report to the annual accounts –** The Trust should develop an Integrated timetable for the production of the Annual Report, Quality Account and accounts in line with best practice to set out key roles and responsibilities to facilitate the production of a high quality, integrated document in a timely manner. ■ We have identified two prior year recommendations that require further action by management, the most significant being the identification and classification of deferred income and accruals which the Trust has partially implemented. The accounting treatment is consistent with previous years.

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Headlines (cont.)

Whole of Government Accounts	■ We intend to issue an unqualified confirmation to the NAO regarding the Whole of Government accounts submission, made through the Trust's submission of the summarisation schedules to the Department of Health.
Quality Accounts	We have completed our audit of the Trust's 2013/14 Quality Accounts. We worked proactively during the year with the Trust to agree an earlier timetable for the production and audit of the Quality Accounts, in order to report to the Audit Committee prior to submission deadline on 30 June 2014. Overall, based on the work performed: ■ You have achieved a clean limited assurance opinion on the content of your Quality Account, in compliance with Quality Account Regulations which could be referenced to supporting information and evidence provided by the Trust. This represents an unqualified audit opinion on the Quality Account. ■ This year we have also tested two of the four quality indicators specified by the Audit Commission as suitable for substantive testing at the Trust. In conjunction with management we selected the indicators relating to Acute Trusts: Percentage of patients risk-assessed for venous thromboembolism and rate of clostridium difficile infections. ■ Our detailed findings following the audit of the Quality Account are presented to you in a separate report; see our external assurance report on your 2013/14 Quality Accounts.
Public Interest Reporting	■ We have a duty to refer any matter to the Secretary of State if we have a reason to believe that the Trust is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency. We also have a duty to consider whether, in the public interest, to report on any matter that comes to our attention in order for it to be considered by the Trust or brought to the attention of the public. ■ We did not issue a report to the Secretary of State or a report in the public interest in 2013/14.
Fraud	■ We have a responsibility to consider fraud and we addressed this in our assessment of your controls framework. We have also reviewed your arrangements for the prevention and detection of fraud and corruption, alongside our use of resources work. ■ This work is complete and has not identified any matters to which we wish to draw to your attention.

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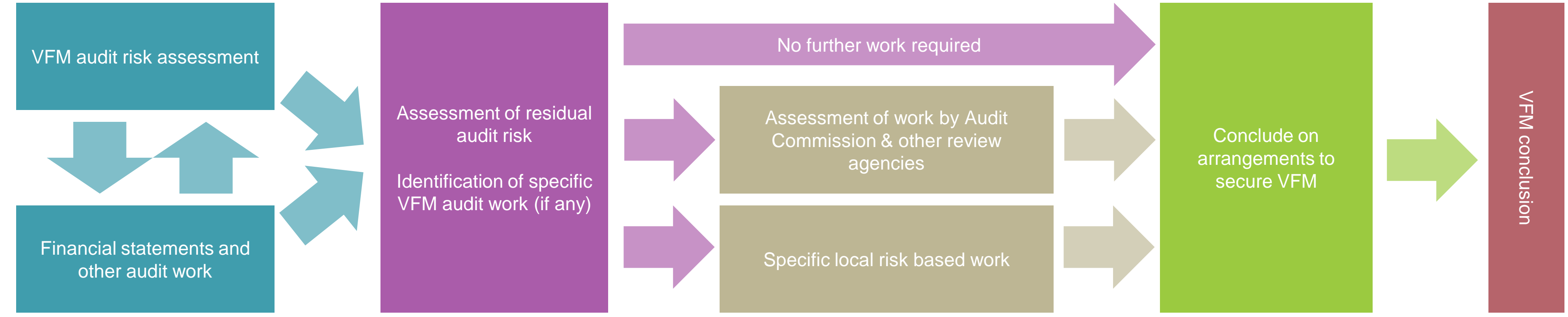
Background

Auditors are required to give their statutory VFM conclusion based on two criteria specified by the Audit Commission. These consider whether the Trust has proper arrangements in place for:

- securing financial resilience: looking at the Trust's financial governance, financial planning and financial control processes; and
- challenging how it secures economy, efficiency and effectiveness: looking at how the Trust is prioritising resources and improving efficiency and productivity.

We follow a risk based approach to target audit effort on the areas of greatest audit risk. We consider the arrangements put in place by the Trust to mitigate these risks and plan our work accordingly.

The key elements of the VFM audit approach are summarised in the diagram below.



Conclusion

We have concluded that the Trust has made proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

VFM criterion	Met
Securing financial resilience	✓
Securing economy, efficiency and effectiveness	✓

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Use of Resources (cont.)

Key Findings

In the table below, we have summarised the scope of our work along with our key findings. The results of this work will be reflected in our VFM conclusion.

Criteria and scope of our work	Key findings from our work
1) Securing financial resilience We considered the Trust's arrangements for ensuring robust financial governance, planning and control. As a result, we focused on whether the Trust has robust systems and processes to manage effectively financial risks and opportunities, and to secure a stable financial position that enables it to continue to operate for the foreseeable future.	■ Regular financial reporting to the Board facilitates the Trust in its decision making in the short and medium term. The Trust has a long term financial model in place which has been regularly updated to reflect the Trust's plans to build the Midland Metropolitan Hospital. ■ The Trust has delivered against its budget in 2013/14. An update to the planned surplus of £4.6 million was submitted to the Trust Development Authority as part of its Quarter Three reporting and the Trust subsequently achieved the £6.7 million revised surplus, excluding the impairment adjustment of £8.9 million. As part of its 2014/15 planning, the Trust has identified that this represents a normalised outturn of £0.2 million. ■ The Trust assesses itself against the Continuity of Services Risk Rating (COSRR) methodology applied by the Trust Development Authority. The Trust has a current COSRR of 4 which is not indicative of any immediate significant risks. ■ The Trust achieved £21.8 million (98 per cent) of cost improvement programme savings within its transformation programme. This is against an initial target of £22.3 million, a £0.5 million shortfall. The Trust has assessed that the full year effect of these savings is £19.8 million which is £2.4 million (12 per cent) below plan. ■ Based on the evidence presented in 2013/14, the Trust has delivered its targets and demonstrated it has adequate arrangements in place to secure financial resilience.
2) Securing economy, efficiency and effectiveness We considered the Trust's arrangements for prioritising resources and achieving efficiency and productivity. We also considered the Trust's performance in the year. As a result, we focused on how the Trust is prioritising its resources within tighter budgets, for example, by achieving cost reductions and by improving efficiency and productivity.	■ The Trust has achieved the majority of its key performance targets throughout the year, but has not achieved the Emergency care four hour maximum wait – the Trust achieved 94.5% for the year against the target of 95%. We note the Trust has achieved the target during the winter period with the exception of February 2014. ■ The Trust continues to experience challenges in respect of its workforce. It has not achieved its targets in relation to bank and agency shifts, exceeding the target number of nurse bank shifts by 30 per cent and number of nurse agency shifts by 710 per cent. This has contributed to workforce numbers being 308 above plan. Workforce is forming a key part of the Transformation Savings Plans for 2014/15 with workforce impact considered as part of each scheme. ■ The Trust has recognised the challenges presented to the NHS economy and its own financial position against its long term financial plan and has responded by setting up a Trust wide Project Management Office (PMO) to manage its CIPs, having initiated a local trial within Medicine & Emergency Care. ■ The Trust reported on 29 May 2014 that it has identified schemes for £13.9 million (67%)of the £20.6million target in 2014/15, with detailed action plans in place to identify new opportunities and develop robust delivery plans to address the shortfall by 20 June 2014, and deliver a surplus of £3.1 million in 2014/15.

Our conclusion

As a result of our work, we are satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2014.

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To review your financial statements we perform tasks split between those which are undertaken before, during and after the accounts production. These are summarised below:

Work Performed	Accounts production stage		
	Before	**During**	**After**
1. Business Understanding: review your operations.	✓	✓	–
2. External Audit Plan: presented to Audit Committee	✓	–	–
3. Controls: assess the control framework.	✓	–	–
4. Prepared by Client Request (PBC): issue our PBC	✓	–	–
5. Accounting standards: agree the impact of any new accounting standards.	✓	✓	–
6. Accounts Production: review the accounts production process.	✓	✓	✓
7. Testing: test and confirm material or significant balances and disclosures.	–	✓	–
8. Representations and opinions: seek and provide representations before issuing our opinions.	✓	✓	✓

We have completed the first seven stages of the process. We report our key findings from each stage in the remainder of this section.

Business Understanding and External Audit Plan.	■ In our *2013/14 External Audit Plan* we assessed your current operations to identify significant issues that might have a financial consequence. ■ We have provided an update on the key accounts audit issues on page 11.
Assessment of the Control Framework	■ We have assessed the effectiveness of your key financial system controls in place that prevent and detect material fraud and error. We reported in our progress report to the Audit Committee in April 2014 that we had identified that the finance had not performed bank reconciliations between October 2013 and February 2014 due to a member of the Finance team leaving their post. We have reviewed the bank reconciliation performed at the year end following completion by the finance team. We have raised a recommendation in respect of further enhancements that the finance team should make to this process to further enhance the process and presentation of the audit trail. ■ We evaluated the work of your internal audit function, provided by Coventry and Warwick Audit Services in accordance with ISA 610. We found that we were able to rely on their work that we set out in our Internal and External Audit Protocol that was presented to the Audit Committee in October 2013. We performed more work in respect of the Trust's bank reconciliations and considered staff continuity as part of our audit and raised a recommendation in Appendix A. We will establish a similar working protocol with the incoming Internal Auditors.

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Prepared by Client Request	■ We issued our final prepared by client list to the Trust on 10 January 2014. This document summarises the working papers and evidence we ask you to collate as part of the preparation of the financial statements. We refreshed this in 2013/14 to incorporate the revisions following our debrief of the 2012/13 audit process with the Associate Director of Finance in August 2013. ■ The prepared by client list incorporated the requirement to produce an integrated Annual Report, Quality Account and accounts timetable, in line with the 2012/13 debrief actions presented to the Audit Committee in October 2013, and a copy of the Annual Report cross referenced to the requirements in the Manual for Accounts. The Annual Report was not provided until 23 May and did not signpost key requirements such as the Strategic Report and a Sustainability Report. Whilst the content was substantially included, the Trust had to enhance its off-payroll disclosures. ■ The majority of working papers in respect of the accounts were presented to us in line with the agreed timetable and were of a high quality.
Accounting Standards	■ We work with you to understand the changes to accounting standards and other technical issues. ■ The finance team were proactive in responding to changes to the accounts required by the Department of Health's Manual for Accounts (MfA) and changes to accounting standards. This included the early consideration of the consolidation of the Trust's charitable fund, with the deferral of IAS 27 no longer applying for NHS bodies. The Trust concluded that whilst falling under the scope of IAS 27 under the control concept, the charitable fund was not material for the purposes of the accounts. We agreed with this conclusion. ■ The key areas we have identified are considered on page 11.
Accounts Production	■ We received the Trust's submitted accounts on 22 April 2014 in accordance with the Department of Health's deadline. There were some minor presentational amendments made to these accounts, particularly to the trade payables, before the audit started. However, none of these amendments significantly hindered the progress of the audit. We identified further presentational adjustments during the audit in respect of the financial instruments and related party transactions notes but these have been amended. ■ The accounting policies, accounting estimates and financial statement disclosures are in line with the requirements of the Department of Health. ■ The responsibility for the production of the accounts, and supporting consolidation schedules, currently sits with the Associate Director of Finance. It is our experience at other Trusts that the responsibility for the production of the accounts, and incorporation of updates to guidance, sits with the Financial Controller. The responsibility of the Associate Director of Finance or Director of Finance is then limited to quality review to ensure a robust set of financial statements and associated reports is submitted to the Department of Health ahead of the draft deadline and for audit. We have raised a recommendation in Appendix A for the Trust to review its arrangements going forward. ■ As in previous years, we will debrief with the Finance team to share views on the final accounts audit. We will look to include more members of the wider finance team. ■ Trust finance staff were available throughout the audit visit to answer our queries as they arose. ■ We thank the finance team for their co-operation throughout the visit which allowed the audit to progress smoothly and complete within the allocated timeframe.

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Accounts (cont.)

Testing	■ During the audit we identified two issues which have not been adjusted as they have no material effect on the financial statements. In accordance with ISA 260 we must communicate these uncorrected misstatements to the Audit Committee. We have summarised this issue at Appendix C. In summary, we identified that the Trust had recognised the following balances as provisions as opposed to deferred income: ■ £3.0 million in respect of the Right Care, Right Here project in respect of funding received in previous years from commissioners; and ■ £1.4 million in respect of other programmes, including interpretation services to be provided in 2014/15 for which the Trust has received the cash in advance. This treatment is consistent with that adopted in previous years. ■ These items have been accounted for as provisions but we do not consider that these items meet the definition of a provision under IAS 37- Provisions, Contingent Liabilities and Contingent Assets. The total value of these balances is £4.4 million and is therefore not material in the context of the accounts as a whole. ■ Our findings related to areas of high audit risk are shown on page 11.
Representations and Opinions	■ You are required to provide us with representations on specific matters such as your financial standing and whether the transactions in the accounts are legal and unaffected by fraud. We provided a draft of this representation letter to the Director of Finance on 30 May 2014. ■ We draw your attention to the requirement in our representation letter for you to confirm to us that you have disclosed all relevant related parties to us. ■ This year we are asking management to provide a specific representation on the provisions for the Right Care, Right Here monies and other programmes and services yet to be provided by the Trust at the Statement of Financial Position (SOFP) date.
Other Matters	■ We are required under ISA 260 to communicate to you any matters specifically required by other auditing standards to be communicated to those charged with governance; and any other audit matters of governance interest. ■ We have not identified any other matters to specifically report.

Next Steps

Following consideration of the issues highlighted in this report, the Audit Committee will sign the management representations letter at the Board meeting on 5 June 2014. Once we have received your representations we issue our audit opinion. For 2013/14 this provides confirmation that:

- your financial statements present a true and fair view;
- you have complied with the Department of Health’s disclosure requirements set out in the Trust Financial Reporting Manual in the preparation of your AGS and we are not aware of any inconsistencies with the information that you have recorded within this statement and our other work;
- we have read your Annual Report and in our view it does not contain information which is inconsistent with your financial statements; and
- the numerical part of your Remuneration Report has been presented in a way which complies with the accounting requirements as set out in the NHS Trust Financial Reporting Manual.

Except for the uncorrected misstatement outlined in Appendix C, we do not have any other matters that we wish to draw to your attention prior to issuing this opinion.

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Accounts (cont.)

Independence and Objectivity

ISA 260 also requires us to make an annual declaration that we are in a position of sufficient independence and objectivity to act as your auditors. We have provided this declaration at Appendix D.

Audit Fees

Our fee for the audit in 2013/14 was £111,107 plus VAT. This fee was inline with the scale fee highlighted within our audit plan and communicated to the Audit Committee. The fee for our NHS Quality accounts work was £10,000.

During the course of the year, we have also completed a piece of non audit work in respect of a review of the Trust's Long Term Financial Model (LTFM) to challenge where improvements could be made to the basis of preparation and provide high level commentary on key assumptions underlying the LTFM. Our fee for this work was £11,000. This work was performed by a KPMG team separate to the audit team and we are required to obtain Audit Commission approval for additional pieces of work. No concerns were raised by the Audit Commission.

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Results of our testing on areas of high audit risk

In our External Audit Plan 2013/14, presented to you in January 2014, we identified the areas assessed as significant risks in terms of their impact on our financial statements audit opinion. We have now completed our testing of these areas and set out our final evaluation following our substantive work.

Areas of SIGNIFICANT audit risk	Summary of findings
Deferred Income Audit areas affected - Income - Agreement of balances - Provisions	- We reported in 2012/13 that the Trust had recognised a provision of £1.0 million in respect of incomplete treatments for patients receiving high cost drugs (Lucentis). In 2013/14 this has been released to the SOCI in recognition of relevant Lucentis services and expenditure arising during the course of the year. - The Trust has also released the £1.0 million in respect of the Transitional Funding Framework during 2013/14 as change related projects have occurred. - The Trust maintains a provision in respect of the “Right Care, Right Here” programme and this has increased by £0.3 million during the year to £3.0 million following receipt of additional income of £1.9 million and project related expenditure of £1.6 million. We have previously reported that we do not consider to meet the requirements of IAS 37 Provisions, Contingent Liabilities and Contingent Assets and we have recommended audit adjustments to release these monies to the SOCI. This is an unadjusted audit difference and reported in Appendix C. 2013/14 is the last year in which new receipts in respect of this project funding are expected and the Trust expects the remaining provision to be fully consumed on the project by 2015/16. - We reviewed the Agreement of Balances exercise to ensure that there are no discrepancies with other bodies that could indicate additional income recognition issues. No discrepancies were identified from this process, however we will be required to disclose to the NAO the “transformation monies” noted above because their inclusion in provisions means that they were not included within the Agreement of Balances exercise. - Our testing also identified balances in provisions of £1.4 million relating to income received in respect of programmes and services, which were not delivered by the SOFP date and reflect income for the 2014/15 period. These should have been recorded as deferred income. We have included an unadjusted audit difference in Appendix C.

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Accounts (cont.)

<table>
<tr><th colspan="2">Areas of SIGNIFICANT audit risk</th><th>Summary of findings</th></tr>
<tr><td>Valuation of land and buildings</td><td>Audit areas affected
■ Valuation of PPE</td><td>■ A valuation of the Trust’s land and buildings was performed by the District Valuer during the year. The valuer provided a valuation of £198.9 million for the estate, with revised net book values and asset lives reflected in the Fixed Asset Register and accounts accordingly.
■ We reviewed instructions to the valuer and the basis of the valuation and ensured that this reflected the capital expenditure incurred during the course of the year and the Grove Lane site. As a result of our review, we have considered the judgements and estimates used to be balanced.
■ The valuation resulted in an overall net impairment to the SOCI of £8.9 million, of which £7.9 million related to land which predominantly related to the acquisition of Grove Lane under in preparation for the new Midland Metropolitan Hospital. We have reviewed the Land Acquisition Group minutes during the course of the year and not identified any concerns in respect of our Value for Money opinion.</td></tr>
<tr><td>Consolidation of SWBH Charities</td><td>Audit areas affected
■ Income
■ Agreement of balances
■ Provisions</td><td>■ From 2013/14, the Treasury dispensation not to consolidate was no longer available and NHS bodies therefore had to consolidate any material NHS charitable funds which they determine to be subsidiaries.
■ The Trust performed an assessment to determine whether it was required to consolidate Sandwell and West Birmingham Hospitals Charities. The Trust concluded that the transactions, assets and liabilities of the Charity are not currently material in the context of the accounts of the Trust.
■ We have reviewed the assessment prepared by the Trust, which was also approved by the Audit Committee and concur with the Trust’s assessment.
■ The Trust has made appropriate disclosures within its accounting policies and as a separate note to the accounts.</td></tr>
</table>

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Accounts (cont.)

In our *External Audit Plan 2013/14* we also reported that we would focus on other areas as specifically required by professional standards. These risk areas were management override of controls, and the fraud risk of revenue recognition.

The table below sets out the outcome of our audit procedures and assessment on these risk areas.

Other areas of audit focus		Summary of findings
Management override of controls	Audit areas affected ■ All areas	Our audit methodology incorporates the risk of management override as a default significant risk. Management is typically in a unique position to perpetrate fraud because of its ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. We have not identified any specific additional risks of management override relating to this audit. In line with our methodology, we carried out appropriate controls testing and substantive procedures, including over journal entries, accounting estimates and significant transactions that are outside the normal course of business, or are otherwise unusual. There are no matters arising from this work that we need to bring to your attention.
Fraud risk of income recognition	Audit areas affected ■ None	Professional standards require us to make a rebuttable presumption that the fraud risk from revenue recognition is a significant risk. In our External Audit Plan 2013/14 we reported that we do not consider this to be a significant risk for NHS bodies as there is unlikely to be an incentive to fraudulently recognise revenue. This is still the case. Since we have rebutted this presumed risk, there has been no impact on our audit work.

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Appendix A: Key issues and recommendations

This appendix summarises the recommendations that we have identified from our work. We have given each of our recommendations a risk rating (as explained below) and agreed with management what action you will need to take.

Priority rating for recommendations		
Priority one: issues that are fundamental and material to your system of internal control. We believe that these issues might mean that you do not meet a system objective or reduce (mitigate) a risk.	*Priority two*: issues that have an important effect on internal controls but do not need immediate action. You may still meet a system objective in full or in part or reduce (mitigate) a risk adequately but the weakness remains in the system.	*Priority three*: issues that would, if corrected, improve the internal control in general but are not vital to the overall system. These are generally issues of best practice that we feel would benefit you if you introduced them.

#	Risk	Issue, Impact and Recommendation	Management Response/Responsible Officer/Due Date
1		**Resilience and capacity of the Finance team** We reported to the Audit Committee in October 2013 a series of actions agreed as a result of our debrief of the 2012/13 audit process. One such action was to review the roles and responsibilities for staff involved in accounts and working paper production as part of future succession planning and sharing the workload of the financial accounts team. This followed the departure of senior members of the finance team and the department's restructure. During our audit of the 2013/14 accounts we have observed that there remains a heavy reliance on the Associate Director of Finance to: ■ recognise detailed changes to accounting and NHS specific submission requirements. These have increased in volume in 2013/14 due to regulatory reporting changes and changes to the structure of the NHS through introduction of NHS England and CCGs; ■ produce the accounts; ■ produce the underlying consolidation schedules; and ■ take the lead responsibility for dealing with audit. In addition, key responsibilities were not identified and reassigned in a timely manner following the departure of the Head of Financial Services, which included the bank reconciliation which we reported following our interim audit. *Continued overleaf*	Agreed. A fundamental review of finance team arrangements is underway and will include benchmarking against relevant peer capacity. **Responsible officer:** Director of Finance **Due Date**: July 2014 Improvements are being made to secure better segregation of duties as staff are recruited to vacant posts and consistent with roles and capability. Capacity within financial services will be strengthened as part of this process. **Responsible officer:** Associate Director of Finance **Due Date**: September 2014 This will include the transfer of key control responsibilities such as bank reconciliation away from the Associate Director of Finance thus creating the capacity to improve the challenge and review process. **Due Date**: June 2014

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Appendix A: Key issues and recommendations (cont.)

#	Risk	Issue, Impact and Recommendation	Management Response/Responsible Officer/Due Date
1	2	**Resilience and capacity of the Finance team (continued)** In our experience, these are responsibilities which are often performed by a Financial Controller and the wider finance team, allowing for higher level review and challenge as part of quality control procedures. ***Recommendation*** The Trust should review the roles and responsibilities of the finance team and benchmark to best practice within other similar sized trusts. The Trust should develop plans to involve members of the wider finance team in the accounts production process to ensure knowledge and skills are shared in order to develop resilience as a team and move away from the reliance on key members of staff.	See overleaf
2	2	**Annual Report** As part of our Prepared By Client (PBC) list issued on 10 January 2014 we requested that the Trust provide us with the Annual Report during our audit so that we could undertake our required review of the Strategic Report, Directors' Report and Remuneration Report. We also requested that the Annual Report be cross referenced to the requirements in the Manual for Accounts, and provided an initial schedule to help with this in the PBC. We commenced our audit on 12 May 2014 and received an initial draft of the annual report on 23 May 2014. This excluded a number of requirements, including some of the new requirements within the Strategic Report and Sustainability Report. The Trust had not taken into account new guidance that NHS Trusts no longer have the option of locally publishing their Annual Report and Summary Financial Statements, full annual report and accounts must be laid before Parliament at which point NHS bodies have discretion as to whether they wish to publish the full document locally or a separate strategic report together with supplementary material. ***Recommendation*** The Trust should develop an integrated Annual Report, Quality Account and Accounts timetable in 2014/15 clearly allocating responsibility for the production of the Annual Report and identifying any changes to requirements. The Trust should ensure that all working papers and supporting documentation requested are prepared to a high standard by the start of the onsite audit. The Annual Report should be cross referenced to the requirements in the Manual for Accounts to facilitate a high level review to ensure a high quality document is presented for audit.	Agreed. Integrated timetable will be produced. **Responsible officer:** Associate Director of Finance **Due Date**: November 2014 Working papers- **Responsible Officer:** Head of Communications **Due Date**: April 2015 Cross referencing: **Responsible Officer:** Head of Communications **Due Date:** May 2015

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Appendix A: Key issues and recommendations (cont.)

#	Risk	Issue, Impact and Recommendation	Management Response/Responsible Officer/Due Date
3	2	**Whole of Government Accounts (WGA)** As part of our interim audit, we obtained your month 9 consolidation schedules and undertook preparatory work to consider the completeness of "other WGA bodies" which are not included within the NHS Agreement of Balances exercise. We based our review on Annex 2 of the *Agreement of Balances Guidance* jointly issued by Monitor, Trust Development Authority, Department of Heath and NHS England in December 2013. We fed back to the finance team that whilst balances and transactions were included in totality, the following counterparties had not been disclosed in line with NAO requirements: ■ NHS Pension Scheme balances for employers and employees contributions and expenditure in respect of employer contributions; ■ HMRC transactions were recorded in respect of NI which should be disclosed as National Insurance Fund transactions; and. ■ National Insurance Fund balances for employers and employees NI contributions and expenditure in respect of employer NI. The finance team subsequently incorporated the majority of these as part of the production of the month 12 consolidation schedules, with the exception of the National Insurance Fund which has subsequently been addressed. We identified two further disclosure omissions within the Whole of Government Account consolidation schedules as part of our work, which the finance team had also identified as part of subsequent agreement of balances work after the submission of the accounts: ■ Health Education England; and ■ NHS Property Services. ***Recommendation*** The Agreement of Balances Guidance is fluid and has been regularly updated throughout the course of the year, particularly with the establishment of new organisations. The Trust should ensure that the Financial Controller regularly reviews the latest WGA guidance in time to produce compliant WGA consolidation schedules for audit.	Agreed. Responsibility for reviewing guidance will be transferred within the revised structure of Financial Services **Responsible officer:** Associate Director of Finance **Due Date:** September 2014

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Appendix A: Key issues and recommendations (cont.)

#	Risk	Issue, Impact and Recommendation	Management Response/Responsible Officer/Due Date
4	2	**Identification and classification of Deferred Income and accruals** Our audit testing identified balances of £3.0 million relating to Transformation Funding in respect of the Right Care, Right Here programme, and £0.5 million which have been classified as provisions but do not meet the definition of a provision as set out in IAS 37 – Provisions, Contingent Liabilities and Contingent Assets. The money received reflects money received for goods or services which have not yet been delivered or performed and hence should be recorded as deferred income. ***Recommendation*** An assessment should be made on the correct treatment and presentation using IAS 18 Revenue Recognition and IAS 37 Provisions. Where income has been received from another NHS body, the accounting treatment should be agreed by the counterparty to ensure consistency.	The Trust considers that it is appropriate to recognise the existence of future liabilities regarding these programmes. 2013/14 accounting is consistent with that adopted in previous years and has been subject to confirm and challenge review by the Audit Committee in January and April 2014
5	3	**Bank reconciliations** We reported within our April 2014 Audit Committee progress report that during our interim audit we had identified that bank reconciliations had not been performed between the period October 2013 and January 2014 following the departure of the Head of Financial Services. The Trust subsequently prepared the bank reconciliations omitted for the year end. We reviewed the year end bank reconciliation to ensure it was fit for purpose and reconciled cash appropriately. The cash balance had been reconciled appropriately, but the audit trail could be enhanced to document support for the reconciling items. This would enable an efficient review by the responsible reviewer in place to ensure segregation of duties. ***Recommendation*** The Trust should review the template bank reconciliation to ensure it captures supporting evidence for reconciling items.	Agreed. The Trust recognises that improvements to both the process and presentation of bank reconciliations can be made and that improvement process has already commenced. As part of the process of handing over responsibility for the production of bank reconciliations, these new processes and methods of presentation will be embedded within operational procedures. **Responsible Officer:** Associate Director of Finance **Due Date**: June 2014.

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Appendix A: Key issues and recommendations (cont.)

#	Risk	Issue, Impact and Recommendation	Management Response/Responsible Officer/Due Date
6	❸	**CIP Reporting** The Trust has taken steps to set up PMO arrangements to manage its costs improvement programme. The reporting of the progress against the Transformation Savings Plan (TSP) in 2012/13 was to the Finance and Investment Committee and relied upon detailed appendices containing financial information for all projects. The reporting did not contain clear exception reporting on a RAG rating basis of those projects at risk or action plans to address those. ***Recommendation*** As part of the new arrangements the Trust should develop focused reporting of CIPs on an exception basis to ensure that reporting to Group meetings and Executive meetings is focused on key risks to delivery and action plans to address any shortfalls identified against plan during the course of the year.	Agreed. **Responsible Officer:** Jayne Dunn, Redesign director. **Due Date**: July 2014.

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Appendix B: Follow up of prior year recommendations

This appendix summarises the progress made to implement the recommendations identified in our ISA 260 Report 2013/14 and re-iterates any recommendations still outstanding.

Number of Prior Year Recommendations	Number of Recommendations implemented	Number outstanding (re-iterated below)
4	2	2

Recommendations Outstanding

#	Risk	Issue and Recommendation	Officer Responsible and Due Date	Status as at May 2014
1	2	**Identification and classification of Deferred Income and Accruals** Our audit testing identified balances of £3.7m relating to Transformation Funding, and £1.4m relating to incomplete treatments which have been classified as provisions, but do not meet the definition of a provision as set out in IAS 37 – Provisions, Contingent Liabilities and Contingent Assets. £5.1m of income received in both 2012/13 and previous financial year has been incorrectly recorded as a provision in the statement of financial position. An assessment should be made on the correct treatment and presentation using IAS18 Revenue Recognition and IAS 37 Provisions. Where income has been received from another NHS body, the accounting treatment should be agreed by the counterparty to ensure consistency. **This recommendation was also made in our 2011/12 ISA260 report.**	The Trust's view is that a potential liability exists to incur expenditure on the projects for which funding was given and therefore it is not appropriate to release these monies to the Statement of Comprehensive Income under IAS18. However, the Trust will review accounting treatment during 13/14 with a view to recognition where appropriate within the overall income and expenditure position, thus reducing or eliminating such balances at 31st March 2014	**Partially Implemented** The Trust still maintains a provision for Right Care, Right Here monies of £3.0 million which is consistent with the prior year. However, it has released provisions in respect of Transition Funding Framework, £1 million, and Lucentis, £1 million.

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Appendix B: Follow up of prior year recommendations

#	Risk	Issue and Recommendation	Officer Responsible and Due Date	Status as at May 2014
2	2	**Verification of Assets** We have undertaken testing as part of the audit to gain assurance over the existence of assets, including physical verification and testing of deeds. Whilst our sample testing did not identify and specific issues we note that the Trust does not undertake a routine physical verification of its assets. This impacts on the ability of the Trust to be assured that all assets recorded in the financial statements exist and remain in use by the Trust. We note that this recommendation has previously been raised by internal audit and was not accepted by management. The Trust needs to make appropriate checks to assure itself of the existence of fixed assets. This should take the form of a rolling physical verification of assets recorded on the asset register.	The Trust considers that close joint working between Finance and other appropriate staff within the Trust (primarily Estates and Medical Engineering) on recording and accounting for assets provides a more robust and timely method of establishing the status of assets than simple physical verification. However, a process will be established during 2013/14 to physically check and record the existence of a sample of assets to provide additional validation of the existence and condition of assets.	Partially Implemented The Trust's outgoing internal auditors undertook sample testing and identified two issues. The Trust should undertake a periodic verification of assets on those assets which are not covered by the Medical Engineering system and hence requiring annual review as part of health and safety checks.

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Appendix C: ISA260 Communication of Audit Differences

We are required by ISA (UK and Ireland) 260 Communication of Audit Matters to Those Charged with Governance to communicate all uncorrected misstatements, other than those that we believe are clearly trivial, to those charged with governance. We are also required to report all material misstatements that management has corrected but that we believe should be communicated to the Audit Committee to assist it in fulfilling its governance responsibilities.

This appendix sets out the audit differences that we identified following the completion of our audit of Sandwell and West Birmingham Hospital NHS Trust for the year ended 31 March 2014.

Unadjusted audit differences

Detailed below are the audit differences that have an effect on the NHS Trust's financial statements. We are satisfied that, although the NHS Trust has not adjusted the accounts to reflect these differences, the total unadjusted difference is not material to the overall reported financial position.

	Statement of Statement of Financial Position (£)/I&E Account (£)	
Issue	**Adverse Impact (Dr)**	**Favourable Impact (Cr)**
Recognition of provision for Right Care, Right Here balances as deferred income	Dr Provisions £3.0 million	Cr Deferred Income £3.0 million
Recognition of provision for other services and programmes	Dr Provisions £1.4 million	Cr Deferred Income £1.4 million.

Adjusted audit differences

We are pleased to report that there were no adjusted audit differences.

Presentational Issues

We identified a number of minor presentational issues during our audit and these have all been amended by the Trust. These included:

- amendments to the financial instruments note which should only disclosure contractual payments, not statutory payments such as VAT and HMRC;
- amendments to the presentation of the remuneration report to reflect new requirements in respect of other pension benefits; and
- amendments to the trade payables note to reflect the appropriate classification of NHS and non NHS accruals.

Other Matters

There are no other matters we wish to bring to your attention.

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Appendix D: Declaration of Independence and Objectivity

Auditors appointed by the Audit Commission must comply with the Code of Audit Practice (the Code) which states that:

'Auditors and their staff should exercise their professional judgement and act independently of both the Audit Commission and the audited body. Auditors, or any firm with which an auditor is associated, should not carry out work for an audited body, which does not relate directly to the discharge of auditors' functions, if it would impair the auditors' independence or might give rise to a reasonable perception that their independence could be impaired'

In considering issues of independence and objectivity we consider relevant professional, regulatory and legal requirements and guidance, including the provisions of the Code, the detailed provisions of the Statement of Independence included within the Audit Commission's Annual Letter of Guidance and Standing Guidance (Audit Commission Guidance) and the requirements of APB Ethical Standard 1 Integrity, Objectivity and Independence ('Ethical Standards').

The Code states that, in carrying out their audit of the financial statements, auditors should comply with auditing standards currently in force, and as may be amended from time to time. Audit Commission Guidance requires appointed auditors to follow the provisions of ISA (UK &I) 260 Communication of Audit Matters with Those Charged with Governance' that are applicable to the audit of listed companies. This means that the appointed auditor must disclose in writing;

- Details of all relationships between the auditor and the client, its directors and senior management and its affiliates, including all services provided by the audit firm and its network to the client, its directors and senior management and its affiliates, that the auditor considers may reasonably be thought to bear on the auditor's objectivity and independence;
- The related safeguards in place; and
- The total amount of fees that the auditor and the auditor's network firms have charged to the client and its affiliates for the provision of services during the reporting period, analysed into appropriate categories, for example, statutory audit services, further audit services, tax advisory services and other non-audit services. For each category, the amounts of any future services which have been contracted or where a written proposal has been submitted are separately disclosed.

Appointed auditors are also required to confirm in writing that they have complied with Ethical Standards and that, in the auditor's professional judgement, the auditor is independent and the auditor's objectivity is not compromised, or otherwise declare that the auditor has concerns that the auditor's objectivity and independence may be compromised and explaining the actions which necessarily follow from his. These matters should be discussed with the Audit Committee.

Ethical Standards require auditors to communicate to those charged with governance in writing at least annually all significant facts and matters, including those related to the provision of non-audit services and the safeguards put in place that, in our professional judgement, may reasonably be thought to bear on our independence and the objectivity of the Engagement Lead and the audit team.

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Appendix D: Declaration of Independence and Objectivity (cont.)

General procedures to safeguard independence and objectivity

KPMG's reputation is built, in great part, upon the conduct of our professionals and their ability to deliver objective and independent advice and opinions. That integrity and objectivity underpins the work that KPMG performs and is important to the regulatory environments in which we operate. All partners and staff have an obligation to maintain the relevant level of required independence and to identify and evaluate circumstances and relationships that may impair that independence.

Acting as an auditor places specific obligations on the firm, partners and staff in order to demonstrate the firm's required independence. KPMG's policies and procedures regarding independence matters are detailed in the Ethics and Independence Manual (‘the Manual’). The Manual sets out the overriding principles and summarises the policies and regulations which all partners and staff must adhere to in the area of professional conduct and in dealings with clients and others.

KPMG is committed to ensuring that all partners and staff are aware of the principles. To facilitate this, a hard copy of the Manual is provided to staff annually. The Manual is divided into two parts. Part 1 sets out KPMG's ethics and independence policies which partners and staff must observe both in relation to their personal dealings and in relation to the professional services they provide. Part 2 of the Manual summarises the key risk management policies which partners and staff must follow when providing such services.

All partners and staff must understand the personal responsibilities they have towards complying with the policies outlined in the Manual and follow them at all times. To acknowledge understanding of and adherence to the policies set out in the Manual, all partners and staff are required to submit an annual Ethics and Independence Confirmation. Failure to follow these policies can result in disciplinary action.

Audit matters

We are required to comply with *ISA (UK and Ireland) 260 Communication of Audit Matters to Those Charged with Governance* when carrying out the audit of the accounts.

ISA 260 requires that we consider the following audit matters and formally communicate them to those charged with governance:

- Relationships that may bear on the firm’s independence and the integrity and objectivity of the audit engagement lead and audit staff.
- The general approach and overall scope of the audit, including any expected limitations thereon, or any additional requirements.
- The selection of, or changes in, significant accounting policies and practices that have, or could have, a material effect on the Trust’s financial statements.
- The potential effect on the financial statements of any material risks and exposures, such as pending litigation, that are required to be disclosed in the financial statements.
- Audit adjustments, whether or not recorded by the entity that have, or could have, a material effect on the Trust’s financial statements.
- Material uncertainties related to event and conditions that may cast significant doubt on the Trust’s ability to continue as a going concern.
- Disagreements with management about matters that, individually or in aggregate, could be significant to the Trust’s financial statements or the auditor’s report. These communications include consideration of whether the matter has, or has not, been resolved and the significance of the matter.
- Expected modifications to the auditor’s report.

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Appendix D: Declaration of Independence and Objectivity (cont.)

Audit matters (cont.)

- Other matters warranting attention by those charged with governance, such as material weaknesses in internal control, questions regarding management integrity, and fraud involving management.
- Any other matters agreed upon in the terms of the audit engagement.

We continue to discharge these responsibilities through our attendance at audit committees, commentary and annual audit letter and, in the case of uncorrected misstatements, through our request for management representations.

Auditor Declaration

In relation to the audit of the financial statements of Sandwell and West Birmingham Hospitals NHS Trust for the financial year ending 31 March 2014, we confirm that there were no relationships between KPMG LLP and the Trust, its directors and senior management and its affiliates that we consider may reasonably be thought to bear on the objectivity and independence of the audit engagement lead and audit staff. We also confirm that we have complied with Ethical Standards and the Audit Commission’s requirements in relation to independence and objectivity.

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Appendix E: National Audit Office Group Assurance

As auditors of Sandwell and West Birmingham Hospitals NHS Trust we are required to report to the National Audit Office ('NAO') in connection with the audit of the Department of Health Resource Account, NHS Summarised Accounts and the Whole of Government Accounts (WGA). We intend to issue an unqualified confirmation to the NAO regarding the WGA submission, made through the Trust's submission of the summarisation schedules to Department of Health.

We are required to report any inconsistencies greater than £250,000 between the signed audited accounts and the consolidation data and details of any unadjusted errors or uncertainties in the data provided for intra-group and intra-government balances and transactions. We have provided details of the inconsistencies that we are reporting to the NAO below:

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NHS Trust

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Dudley Road
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KPMG LLP
One Snowhill
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Birmingham
B4 6GH

5 June 2014

Dear Sirs

This representation letter is provided in connection with your audit of the financial statements of Sandwell and West Birmingham Hospitals NHS Trust ("the Trust"), for the year ended 31 March 2014, for the purpose of expressing an opinion:

i. as to whether these financial statements give a true and fair view of the financial position of the Trust as at 31 March 2014 and of its income and expenditure for the financial year then ended; and

ii. whether the financial statements have been prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

These financial statements comprise the Statement of Financial Position, the Statement of Comprehensive Income, the Statement of Cash Flows, the Statement of Changes in Taxpayers Equity and notes, comprising a summary of significant accounting policies and other explanatory notes.

The Board confirms that the representations it makes in this letter are in accordance with the definitions set out in the Appendix to this letter.

The Board confirms that, to the best of its knowledge and belief, having made such inquiries as it considered necessary for the purpose of appropriately informing itself:

Financial statements

1. The Board has fulfilled its responsibilities for the preparation of financial statements that:

   i. give a true and fair view of the financial position of the Trust as at 31 March 2014 and of its income and expenditure for that financial year*;* and

ii. have been prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

The financial statements have been prepared on a going concern basis.

2. Measurement methods and significant assumptions used by the Board in making accounting estimates, including those measured at fair value, are reasonable.

3. All events subsequent to the date of the financial statements and for which IAS 10 *Events after the reporting period* requires adjustment or disclosure have been adjusted or disclosed.

4. The effects of uncorrected misstatements are immaterial, both individually and in aggregate, to the financial statements as a whole. A list of the uncorrected misstatements is attached to this representation letter.

Information provided

5. The Board has provided you with:

   - access to all information of which it is aware, that is relevant to the preparation of the financial statements, such as records, documentation and other matters;
   - additional information that you have requested from the Board for the purpose of the audit; and
   - unrestricted access to persons within the Trust from whom you determined it necessary to obtain audit evidence.

6. All transactions have been recorded in the accounting records and are reflected in the financial statements.

7. The Board confirms the following:

   i. The Board has disclosed to you the results of its assessment of the risk that the financial statements may be materially misstated as a result of fraud.

   ii. The Board has disclosed to you all information in relation to:

   a) Fraud or suspected fraud that it is aware of and that affects the Trust and involves:
      - management;
      - employees who have significant roles in internal control; or
      - others where the fraud could have a material effect on the financial statements; and [ISA (UK&I) 240.39c]

   b) allegations of fraud, or suspected fraud, affecting the Trust's financial statements communicated by employees, former employees, analysts, regulators or others.

   In respect of the above, the Board acknowledges its responsibility for such internal control as it determines necessary for the preparation of financial statements that are free from material misstatement, whether due to fraud or error. In particular, the

Board acknowledges its responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

8. The Board has disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.

9. The Board has disclosed to you and has appropriately accounted for and/or disclosed in the financial statements, in accordance with IAS 37 *Provisions, Contingent Liabilities and Contingent Assets*, all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

   The Board acknowledges in particular the provisions balances of £3.0 million relating to monies received from Commissioners in prior periods for the Right Care Right Here programme and £1.4 million in relation to other programmes for delivery in 2014/15 and future years. The Trust confirms that in its view a potential liability exists and therefore it is not appropriate to release these monies to the statement of comprehensive income.

10. The Board has disclosed to you the identity of the Trust's related parties and all the related party relationships and transactions of which it is aware. All related party relationships and transactions have been appropriately accounted for and disclosed in accordance with IAS 24 *Related Party Disclosures*.

11. The Board confirms that all intra-NHS balances included in the Statement of Financial Position (SOFP) at 31 March 2014 in excess of £250,000 have been disclosed to you and that the Trust has complied with the requirements of the Intra NHS Agreement of Balances Exercise. The Board confirms that Intra-NHS balances includes all balances with NHS counterparties, regardless of whether these balances are reported within those SOFP classifications formally deemed to be included within the Agreement of Balances exercise.

12. The Board confirms that: **Error! Reference source not found.**

    a) The financial statements disclose all of the key risk factors, assumptions made and uncertainties surrounding the Trust's ability to continue as a going concern as required to provide a true and fair view.
    b) Any uncertainties disclosed are not considered to be material and therefore do not cast significant doubt on the ability of the Trust to continue as a going concern.

    The Board further confirms that:

    a) all significant retirement benefits, including any arrangements that are:
       - statutory, contractual or implicit in the employer's actions;
       - arise in the UK and the Republic of Ireland or overseas;
       - funded or unfunded; and
       - approved or unapproved,

       have been identified and properly accounted for; and
    b) all settlements and curtailments have been identified and properly accounted for.

13. From 2013/14 the Trust is required to consolidate any NHS charitable funds which are determined to be subsidiaries of the Trust. The decision on whether to consolidate is dependent upon the financial materiality and governance arrangements of the charitable funds. The Board confirms that, having considered these factors, it is satisfied that the charitable funds do not require consolidation as they are not material to the Trust's financial statements.

This letter was tabled and agreed at the meeting of the Board of Directors on 5 June 2014.

Yours faithfully,

[Director of Finance]

[Chief Executive]

Appendix A to the Board Representation Letter of Sandwell and West Birmingham Hospitals NHS Trust Definitions

Financial Statements

IAS 1.10 states that a complete set of financial statements comprises:

- a statement of financial position as at the end of the period;
- a statement of comprehensive income for the period;
- a statement of changes in equity for the period;
- a statement of cash flows for the period;
- notes, comprising a summary of significant accounting policies and other explanatory information;
- a statement of financial position as at the beginning of the earliest comparative period when an entity applies an accounting policy retrospectively or makes a retrospective restatement of items in its financial statements, or when it reclassifies items in its financial statements.

Material Matters

Certain representations in this letter are described as being limited to matters that are material.

IAS 1.7 and IAS 8.5 state that:

> "Material omissions or misstatements of items are material if they could, individually or collectively, influence the economic decisions that users make on the basis of the financial statements. Materiality depends on the size and nature of the omission or misstatement judged in the surrounding circumstances. The size or nature of the item, or a combination of both, could be the determining factor."

Fraud

Fraudulent financial reporting involves intentional misstatements including omissions of amounts or disclosures in financial statements to deceive financial statement users.

Misappropriation of assets involves the theft of an entity's assets. It is often accompanied by false or misleading records or documents in order to conceal the fact that the assets are missing or have been pledged without proper authorisation.

Error

An error is an unintentional misstatement in financial statements, including the omission of an amount or a disclosure.

Prior period errors are omissions from, and misstatements in, the entity's financial statements for one or more prior periods arising from a failure to use, or misuse of, reliable information that:

a) was available when financial statements for those periods were authorised for issue; and
b) could reasonably be expected to have been obtained and taken into account in the preparation and presentation of those financial statements.

Such errors include the effects of mathematical mistakes, mistakes in applying accounting policies, oversights or misinterpretations of facts, and fraud.

Management

For the purposes of this letter, references to "management" should be read as "management and, where appropriate, those charged with governance".

Related parties

A related party is a person or entity that is related to the entity that is preparing its financial statements (referred to in IAS 24 *Related Party Disclosures* as the "reporting entity").

a) A person or a close member of that person's family is related to a reporting entity if that person:
    i. has control or joint control over the reporting entity;
    ii. has significant influence over the reporting entity; or
    iii. is a member of the key management personnel of the reporting entity or of a parent of the reporting entity.
b) An entity is related to a reporting entity if any of the following conditions applies:
    i. The entity and the reporting entity are members of the same group (which means that each parent, subsidiary and fellow subsidiary is related to the others).
    ii. One entity is an associate or joint venture of the other entity (or an associate or joint venture of a member of a group of which the other entity is a member).
    iii. Both entities are joint ventures of the same third party.
    iv. One entity is a joint venture of a third entity and the other entity is an associate of the third entity.
    v. The entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity.
    vi. The entity is controlled, or jointly controlled by a person identified in (a).
    vii. A person identified in (a)(i) has significant influence over the entity or is a member of the key management personnel of the entity (or of a parent of the entity).

A reporting entity is exempt from the disclosure requirements of IAS 24.18 in relation to related party transactions and outstanding balances, including commitments, with:

a) a government that has control, joint control or significant influence over the reporting entity; and
b) another entity that is a related party because the same government has control, joint control or significant influence over both the reporting entity and the other entity.

Related party transaction

A transfer of resources, services or obligations between a reporting entity and a related party, regardless of whether a price is charged.

Appendix B to the Board Representation Letter of Sandwell and West Birmingham

	Statement of Statement of Financial Position (£)/I&E Account (£)	
Issue	**Adverse Impact (Dr)**	**Favourable Impact (Cr)**
Recognition of provision for Right Care, Right Here balances as deferred income	Dr Provisions £3.0 million	Cr Deferred Income £3.0 million
Recognition of provision for other services and programmes	Dr Provisions £1.4 million	Cr Deferred Income £1.4 million.

Hospitals NHS Trust Unadjusted audit differences

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Annual Governance Statement
SPONSOR (EXECUTIVE DIRECTOR):	Toby Lewis, Chief Executive
AUTHOR:	Simon Grainger-Lloyd, Trust Secretary
DATE OF MEETING:	5 June 2014

EXECUTIVE SUMMARY:

The AGS sets out the system of internal control in place within the Trust which the Chief Executive, in his capacity as Accountable Officer, calls upon to discharge his duties and responsibilities for supporting the achievement of the organisation's policies, aims and objectives and for safeguarding the public funds and the organisation's assets.

The working draft of the 2013/14 Annual Governance Statement (AGS) is presented to the Committee to challenge and confirm the conclusions reached. In particular, are the specific disclosures necessary and complete in respect of the other matters of significance?

REPORT RECOMMENDATION:

The recommendation from the Audit and Risk Management Committee is that the Trust Board approves the signing of the Annual Governance Statement by the Chief Executive.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	x	

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	x	Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	
Clinical		Equality and Diversity		Workforce	

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

The AGS presents an overview of the risk management framework and overall control framework in place within the Trust and as such cuts across most of the Trust objectives and standards.

PREVIOUS CONSIDERATION:

Audit Committee on 5 June 2014

Sandwell and West Birmingham Hospitals NHS

NHS Trust

ANNUAL GOVERNANCE STATEMENT 2013/14

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

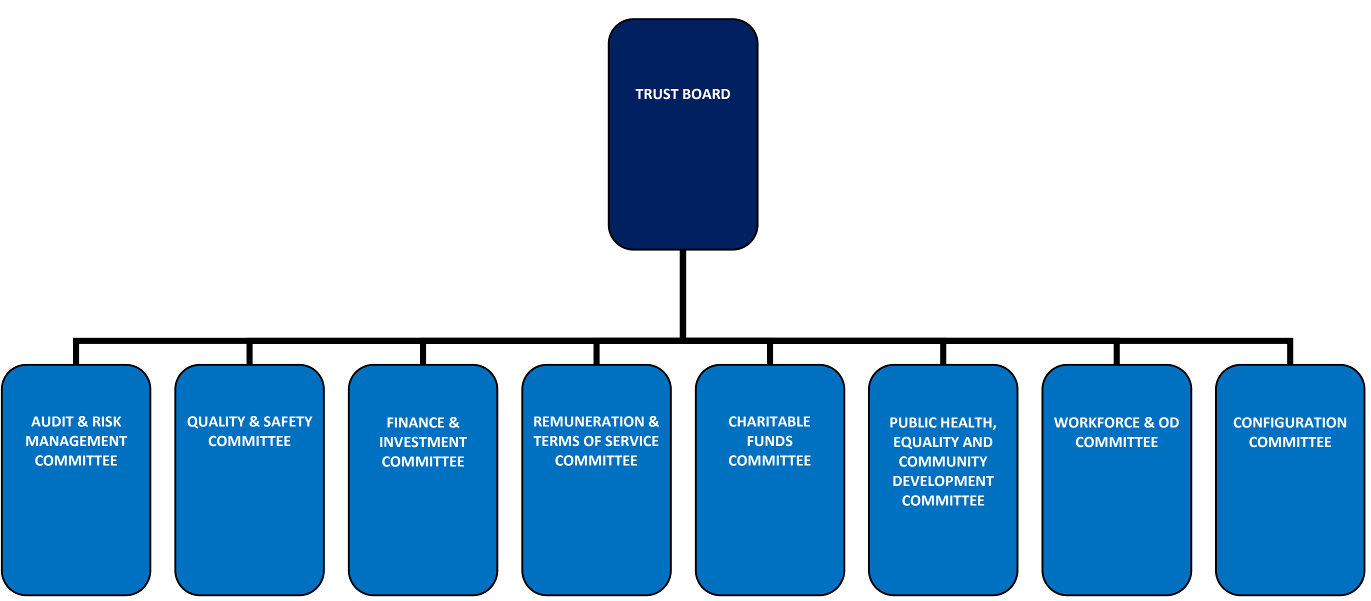
1. SCOPE OF RESPONSIBILITY

1.1 The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum. I have specific duties to ensure safety and to act in partnership with others.

1.2 I discharge these responsibilities as part of a wider system, and with due regard to the role of the Trust Development Authority, its local and national officers. In particular, this year we have played a leading role in the 'Right Care, Right Here' partnership with local authority and CCG colleagues which takes a long-term view of the health and social care system. I have attended the Overview and Scrutiny Committee as required and the Birmingham & Black Country Urgent Care Board which is designed to ensure safe and stable emergency care provision.

2. THE GOVERNANCE FRAMEWORK OF THE ORGANISATION

2.1 The organisation is led strategically by the Trust Board, which this year has been supported by eight committees, which are shown graphically below. At Appendix A the roles and attendees to those committees are described. The Trust Board and its committees are administered by the Trust Secretary who maintains the Directors' Register of Interests and a register of attendance at meetings.



2.2 In June 2013 we completed a review of the committee structure and purpose of the organisation. This review reflected my own arrival in post in April 2013, and the future needs and objectives of the Trust, as an aspirant Foundation Trust organisation. That review was conducted with considerable consultation and with a view to best practice advice. Our intention is that five committees focus on assuring the full Board that we are operating the organisation in line with our agreed long term plans. These committees are:

- Quality and Safety
- Finance and investment
- Workforce and organisational development
- Configuration
- Public Health, Community Development and Equality

The Audit and Risk Management Committee acts on behalf both of the Board and its committees to ensure the accuracy and integrity of the operating system of the Trust. Specific duties are associated with the remaining committees.

Two specific changes made through this review are worth highlighting: we have integrated operating performance into our Quality and Safety Committee at Board level to ensure that there is no possibility that the delivery of national priorities and standards is in conflict with our obligations to safe care and a safe working environment for staff; and we have chosen to focus part of our Board's infrastructure on equality, both the narrow assessment and publishing duty, which we discharged, but also on the wider intention to promote diversity in our workforce and leadership.

2.3 The committee structure is supported by standard reports and performance information. The format and nature of these reports reflects the needs of the committees and Board. We have commissioned Deloitte to provide additional advice on best practice in this field. During the first quarter of the next financial year, we will complete work to not only integrate all data on delivery into a single report, but to standardise the report from ward to Board. This report format will be available Trust-wide on public screens for both staff and visitors to examine.

2.4 The Trust is committed to transparency and public accountability. In 2013/14 we reversed our Board sequence so that public board preceded our private meeting. Accordingly all matters are considered in public unless specifically reserved for private consideration for reasons of commercial confidence or data protection. Integral to the preparation for the Trust's application for Foundation Trust status, have been a number of Board assessments, development activities and opportunities during the year.

2.5 During the year the Board has undertaken considerable work to consider the governance and effectiveness of the strategic leadership. Much of this work has been facilitated by independent sources, including the Board & Committee observations, board member coaching, a mock Board to Board and a series of 360 degree feedback events. The Board has also received and contributed to self-assessments against the Board Governance Assurance

Framework and Quality Governance Assurance Framework during the year. There are other sources which contribute to the judgements of control effectiveness as outlined below.

2.6 Operationally, the Trust delivers care through seven Clinical Groups, each then sub-divided into directorates. The corporate group comprises seven directorates. The vast majority of clinical services report to the Board through the Chief Operating Officer. The Group Directors, along with the Executive Directors, comprise the Clinical Leadership Executive. This monthly body, chaired by the Chief Executive, directs the operational plan for the organisation. It is supported in this task by a series of cross-cutting committees as shown in the graphic below.

2.7 The Trust has and continues to seek to develop local, frontline and clinical leadership. We have engaged expert advisors in that process (Hay Group), who are working with us on an on-going basis to develop the leadership capability of the Trust. That determination to embed systems and a strong safety culture into the organisation is fundamental to our control model and how we ensure that risk is well managed.

3. THE RISK & CONTROL FRAMEWORK

3.1 The Trust has a Board approved Risk Management Strategy which identifies that the Chief Executive has overall responsibility for risk management within the Trust. The Chief Executive is supported with his responsibilities by the Director of Governance. All managers and clinicians accept the management of risks as one of their fundamental duties. Additionally the Strategy recognises that every member of staff must be committed to identifying and reducing risks. In order to achieve this the Trust promotes an environment of accountability to encourage staff

at all levels to report incidents and risks via incident reporting and governance fora which allow for open discussion to prevent their re-occurrence.

3.2 In Clinical Groups, Group Directors supported by Group Directors of Operations and Group Directors of Nursing are responsible for managing risk. In all non-clinical Groups and departments, the appropriate Executive Director is responsible for managing risk via incident reporting and governance / management structures. The Trust has a designated Head of Risk Management within the corporate Group that includes Governance.

3.3 High value risks, unmitigated high risks, and increasingly low likelihood, high impact risks have been considered by the full Board since Quarter 4 2013/14. The risk register process was refreshed during the year to reflect the Trust's new management and committee structure along with standardisation of methodology and format.

3.4 Risk registers are maintained at the relevant management levels: ward / department; directorate; Clinical Group or corporate directorate / project. Risk controls and actions are maintained at each risk register level, with risks featuring on the next managerial level up to ensure higher management levels maintain an oversight of the risks within their service areas and/or higher management input is required. Each Clinical Group, Corporate Directorate or Project report their high (red) risks to the Risk Management Committee, which provides the initial Trust-wide risk register validation stage to ensure consistency in approach, adequacy of controls and that the standardised risk scoring matrix is being utilised. The Risk Management Committee reports validated high (red) risks for inclusion on the Trust Risk Register to the Clinical Leadership Executive, which reviews risk and controls prior to reporting to Trust Board.

3.5 During Quarter 1 2014-15 the risk registers of local teams will be published on the Trust's intranet site in order to promote transparency, reporting and a focus on what might be missed between parts of the system.

Board Assurance Framework

3.6 The Trust has a Board Assurance Framework which includes all key components required, including objectives, risks, controls, positive assurance, gaps in control and/or assurance and remedial action. In a recent review by Internal Audit, it was determined that **Significant Assurance** was provided by the Board Assurance Framework, with further areas for development identified to assist the Trust with continued improvement to the effectiveness of the processes in 2014/15.

3.6 The Board Assurance Framework was considered by the Board three times during the year. The planned refreshed approach to the Board Assurance Framework will take into account the recommendations from the Internal Audit, together with an intention to refocus the BAF more clearly on the key risks to the delivery of the Trust's strategy and strengthen the monitoring arrangement for the BAF by ensuring that it is considered on a twice yearly basis by the Audit and Risk Management Committee.

3.8 The Board Assurance Framework informs the declarations made in this Governance Statement.

3.9 Gaps in controls and assurance of the management of the risks associated with the delivery of a number of the Trust's objectives were identified, however the Trust has taken remedial action to address them which is reported in the update of the Board Assurance Framework.

Quality Account

3.10 The Trust has in place robust processes to develop its annual Quality Account. A task and finish group, led by the Medical Director was introduced in February 2014 which encompassed all the main contributors of the Quality Account. This body developed a schedule which has allowed for weekly progress monitoring of the contributions and creation of links with the production of the Annual Report. The process and progress with developing the Quality Account is overseen by the Audit & Risk Management Committee. The Quality Account is also subject to scrutiny by the Trust's external auditors, including a detailed verification of information provided to support the performance reported against two key performance indicators. This test was undertaken in March 2014 and validation process raised no concerns in terms of the quality of the data provided.

Information security

3.11 Senior responsibility for information security, risks and incidents rests with the Chief Executive, as supported by the Director of Governance. The Director of Governance (Senior Information Responsible Owner) is supported by the Information Governance Manager and Head of Risk Management. The Information Governance Manager manages information security risk and incidents on a day to day basis and seeks support from the Head of Risk Management and the SIRO.

Information security issues are raised through the usual Trustwide incident reporting routes.

An Information Governance Group is established to review the Trust's compliance against the requirement of the Information Governance toolkit, Freedom of Information Act legislation and the action plan to address the recommendations identified following the review by the Information Commissioner's Office.

Counterfraud and Whistleblowing

3.12 The Trust is supported through its Internal Audit function by a Counter Fraud service that reports routinely to the Audit & Risk Management Committee. The service, whose annual workplan is approved by the Audit & Risk Management Committee, is proactive in its role countering fraudulent activity within the Trust. The Trust's whistleblowing policy is currently undergoing a significant refresh to ensure that the processes by which all individuals working in and for the Trust may raise concerns are strengthened. The policy is due for publication in May 2014 and during the year, the Trust's senior managers, including the Trust Board have been provided with an opportunity to give input to the policy.

4. REVIEW OF EFFECTIVENESS OF RISK MANAGEMENT AND INTERNAL CONTROL

4.1 The Internal Auditor's Year End Report and opinion on the effectiveness of the system of internal control is commented on below. The internal auditor's overall opinion is that

Significant Assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. As part of the auditor's opinion, it was emphasised that there was a need to further strengthen the its overall risk management arrangements going forward into 2014/15, including a more frequent review of the arrangements by the Trust Audit & Risk Committee going forward.

The auditor advised that his opinion also took into account the range of individual opinions arising from risk-based audit assignments that had been reported throughout the year. An internal audit plan for 2013/14 was developed to provide independent assurance on the adequacy and effectiveness of systems of control across a range of financial and organisational areas. To achieve this the internal audit plan was divided into two broad categories; work on the financial systems that underpin your financial processing and reporting and then broader risk focused work driven essentially by principal risk areas that had been identified in the Board Assurance Framework.

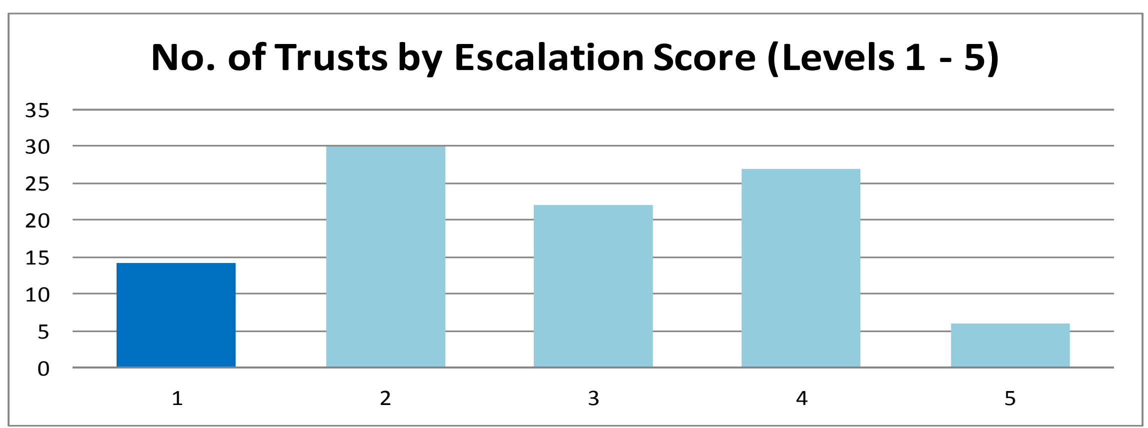
The internal auditor concluded that in his view, taking account of the respective levels of assurance provided for each audit review, an assessment of the relevant weighting of each individual assignment and the extent to which agreed actions have been implemented, that the Trust has a generally sound system of internal control. It was highlighted however that notwithstanding this, the Trust would need to ensure it delivers overall improvements in its data quality management and arrangements going forward.

4.2 Building on the accreditation in 2012/13, in early 2014, the Trust gained accreditation against CNST maternity standards at Level 3. The Trust retains accreditation against NHSLA general standards at Level 2.

4.3 During the year, as part of the monthly Quality Report, the Board received a summary of the Care Quality Commission's Quality & Risk Profile (QRP). Overall the QRP showed the Trust as being at a low risk of non-compliance with the CQC's 16 essential standards of quality and safety. The data sources include the Stroke Improvement National Audit Programme, PROMs (groin hernia surgery and knee replacement), the CQC A&E Survey and Dr Foster Intelligence. From Autumn 2013 the Quality & Safety Committee also received the outcome of the CQC Intelligent Monitoring assessment, rating the Trust as initially at 4 out of possible 6 and in March 2014, 5 out of 6, indicating a low risk of non-compliance against the Essential Standards.

4.4 During the year there was one significant data security lapse that has warranted reporting to the Information Commissioner's Office. This incident concerned a confidentiality breach of patient-sensitive information where a third party viewed this on a computer in a waiting room. Actions have been put in place to prevent a reoccurrence of this incident, however the ICO are still conducting their investigation and remain to provide final feedback. During the period, the Trust initiated an assessment by Information Commissioner's Office, which although did not highlight any major non-compliance against Information Governance standards, did result in a **Limited** level of assurance. This is of concern and greater emphasis will be placed during 2014/15 on scrutiny of these issues at Executive level.

4.5 The Trust is evaluated through the TDA accountability framework. The latest assessment, shown below, indicates that we have the highest possible ratings within that framework. This reflects continued and improved performance in a number of domains, including emergency care, infection control, and elective access. [An external report on the systems we use for elective access is awaited, and if received prior to publication will be reflected in revisions to this document.]



TDA Winter Report (August 2013 - January 2014)

Escalation Scores Level		Trusts
1	No Identified Concerns	14 (inc. Sandwell)
2	Emerging Concerns	30
3	Concern Requiring Investigation	22
4	Material Issue	27
5	Formal Action Required	6

4.6 There are three areas of control concern which require further work during 2014-15.

- In 2012/13 significant long term lapses in the system to manage 18 week data integrity were identified. I reported on those issues in the 2012/13 report. Good progress in resolving those issues was made in the early part of 2013/14. I indicated in reporting on 2012/13 that these may be a symptom of some wider data quality issues in the Trust. During 2013/14 we identified a number of further issues on data quality and accordingly established a Board level taskforce to tackle the subject, with advice from our incoming auditors and with involvement from commissioners. This has made good progress both in creating standard operating protocols for data and in establishing a data quality kite-mark for information. I am satisfied both that our reported data (where the source data is from the Trust) is materially accurate and that we have a good basis for future data quality control.

- We reported five Never Events during 2013/14, of which four took place during the year itself. A wide-ranging audit of controls associated with Never Events has taken place which provides a basis for forward performance tracking at a very local level. Remedial work within Ophthalmology has given rise to an important process of Always Events, which provides a basis for confidence in future performance. In addition we have initiated the

use of the Manchester Patient Safety tool to assess our safety culture at team level. This will be developed across the coming two years and will be used alongside, though not as part of our performance oversight of clinical teams. I am satisfied that we have a greater measure of control than at the outset of the year, but we will need to maintain our current trajectory of improvement in the governance of our theatre processes.

- The Trust has continued its tradition of strong financial performance. We have secured both our control total and controlled pay expenditure in line with budgets. Our non-pay performance shows considerable variation to plan and considerable in year variation. We have initiated work to introduce revised controls and revised reporting arrangements to ensure that, as budgetary pressures tighten, we are able to understand readily the data and the day to day reality. Unlike the other two issues of concern to which I am drawing attention this has, to date, not given rise to performance difficulty, but it is an area on which we intend to focus on the coming months.

5 Concluding remarks

5.1 With the exception of the internal control issues that I have outlined in this statement, my review confirms that Sandwell & West Birmingham Hospitals NHS Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Signed ……………………………………. Toby Lewis, Chief Executive (On behalf of the Board)

Date 28 April 2014

2013-14 Annual Accounts of Sandwell & West Birmingham Hospitals NHS Trust

Appendix A – Purpose and attendance record of Trust Board and its Committees

TRUST BOARD

Chair: Trust Chairman

Frequency: Twelve times a year (note given the Board & Committee schedule revisions wef January 14, no meeting was held in January 2014)

Membership: Seven Non Executive Directors; Seven Executive Directors. Also in attendance are two advisory Executive Directors (non voting), a Non Executive Designate and the Trust Secretary

MEMBERS	DATE											
	25/4/13	30/5/13	6/6/13	27/6/13	25/7/13	29/8/13	26/9/13	31/10/13	22/11/13	19/12/13	6/2/14	6/3/14
Richard Samuda (Ch)	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓
Clare Robinson	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓
Gianjeet Hunjan	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓
Sarindar Sahota	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Richard Lilford#1	✓	A	A	✓	✓	A	A	A	✓	A		
Olwen Dutton	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	A	✓
Harjinder Kang	✓	✓	A	✓	✓	A	✓	✓	✓	A	A	✓
Mike Hoare#7											✓	✓
Toby Lewis	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Robert White#5	✓	✓	✓	✓	✓	A	✓	✓	✓	✓		
Tony Waite#6											✓	✓
Rachel Overfield#2	✓	✓	✓	✓	✓	✓						
Colin Ovington#4												
Rachel Barlow	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Roger Stedman	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓
Mike Sharon	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kam Dhami	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Linda Pascall#3							✓	✓	✓	✓		

KEY:

✓	Attended
A	Apologies tendered
(shaded)	Not in post or not required to attend

AUDIT AND RISK MANAGEMENT COMMITTEE

Chair: Non–Executive Director

Purpose: The purpose of the Committee is to provide the Board with assurance concerning the establishment and maintenance of an effective system of governance, risk management and internal control across the Trust's activities that support the achievement of the organisation's objectives.

Frequency: Five times a year, including a specific meeting to review and approve the annual accounts

Membership: Five Non-Executive directors (excluding the Chair). The Directors of Finance and Governance has a standing invitation to attend and other Executives may attend when requested.

Attendance:

	9/5/13	6/6/13	22/10/13	30/1/14
Gianjeet Hunjan (Ch)	✓	✓	✓	✓
Clare Robinson	✓	✓	A	✓
Sarindar Sahota	✓	✓	✓	✓
Harjinder Kang	✓	A	✓	✓
Olwen Dutton	A	✓	✓	✓

KEY:

✓	Attended
A	Apologies tendered
	Not in post or not required to attend

QUALITY & SAFETY COMMITTEE

Chair: Non–Executive Director

Purpose: The purpose of the Committee is to provide the Board with assurance concerning all aspects of quality and safety relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients and the delivery of Trust's long term quality goals as set out in the Quality & Safety strategy.

Frequency: Monthly

Membership: Five Non-Executive Directors and six of the Executive Directors with specialist advisers in attendance when required

MEMBERS	DATE										
	19/4/13	24/5/13	21/6/13	19/7/13	23/8/13	20/9/13	25/10/13	22/11/13	31/1/14	28/2/14	28/3/14
Olwen Dutton (Ch)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A
Richard Samuda	✓	✓	A	A	✓	✓	✓	✓	✓	✓	✓
Gianjeet Hunjan			✓	✓	A	✓	✓	✓	✓	✓	✓
Sarindar Sahota	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Richard Lilford#1	A	A	A	✓	✓	A	A	A			
Rachel Overfield#2	✓	A	✓	A	✓						
Linda Pascall#3						✓	A	✓			
Colin Ovington#4									✓	✓	✓
Roger Stedman	✓	✓	✓	A	A	✓	A	✓	✓	✓	✓
Rachel Barlow	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	A
Kam Dhami	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	A
Robert White#5	✓	A	A	A	A	✓	A	✓			
Tony Waite#6									✓	A	A

NOTES:

#1 Richard Lilford resigned wef January 2014
#2 Rachel Overfield resigned wef September 2013
#3 Linda Pascall took up post as Acting Chief Nurse September – December 2013
#4 Colin Ovington appointed as Chief Nurse wef December 2013
#5 Robert White resigned wef January 2014
#6 Tony Waite appointed as Director of Finance & Performance Management wef January 2014

KEY:

✓	Attended
A	Apologies tendered
(shaded)	Not in post or not required to attend

2013-14 Annual Accounts of Sandwell & West Birmingham Hospitals NHS Trust

FINANCE AND INVESTMENT COMMITTEE

Chair: Vice Chair

Purpose: The purpose of the Committee is to provide the Board with assurance concerning the delivery of Trust's financial plans, adherence to the Trust's investment policy and robustness of major investment decisions. The long term focus for the Committee will be the delivery of the Medium Term Financial Strategy including the Long Term Financial Model (addressing both revenue and capital), with a view to recommending its adoption to the Board when assurance gained.

Frequency: Alternate months from September 2013; monthly prior to this

Membership: Three Non-Executive directors, CEO, Director of Finance and Chief Operating Officer

MEMBERS	DATE								
	19/4/13	24/5/13	21/6/13	19/7/13	23/8/13	20/9/13	22/11/13	31/1/13	28/3/14
Clare Robinson (Ch)	✓	✓	✓	✓	A	✓	✓	✓	✓
Richard Samuda	✓	A	A	A	✓	✓	✓	✓	✓
Harjinder Kang	✓	✓	✓	✓	✓	✓	✓	✓	✓
Robert White#1	✓	✓	✓	✓	A	✓	✓	▒	▒
Tony Waite#2	▒	▒	▒	▒	▒	▒	▒	✓	✓
Rachel Barlow	✓	✓	✓	✓	A	✓	✓	✓	✓

NOTE:
#1 Robert White resigned wef January 2014
#2 Tony Waite appointed as Director of Finance & Performance Management wef January 2014

KEY:

✓	Attended
A	Apologies tendered
▒	Not in post or not required to attend

2013-14 Annual Accounts of Sandwell & West Birmingham Hospitals NHS Trust

REMUNERATION AND TERMS OF SERVICE COMMITTEE

Chair: Trust Chair

Purpose: The purpose of the Committee is to provide the Board with advice concerning the terms and conditions of employment, including the remuneration packages for the Chief executive and the Executive Directors. The Committee will also seek assurance on the robustness of the plans for the delivery of Trust's reward and recognition strategy for the Chief Executive & Executive Directors

Frequency: The committee meets as required

Membership: All Non-Executive Directors.

Attendance:

MEMBERS	27/6/13	29/11/13
Richard Samuda	✓	✓
Clare Robinson	✓	✓
Sarindar Sahota	✓	✓
Gianjeet Hunjan	✓	✓
Richard Lilford	✓	A
Olwen Dutton	✓	✓
Harjinder Kang	✓	✓

KEY:

✓	Attended
A	Apologies tendered
	Not in post or not required to attend

CHARITABLE FUNDS COMMITTEE

Chair: Non-Executive Director

Purpose: To provide the Board with assurance concerning adherence to the wishes of donors by monitoring the use of funds and the benefits gained. The Committee will also seek assurance on the robustness and progress with the delivery of the Trust's fundraising strategy.

Frequency: Four times per year

Membership: All voting Directors are Trustees, however they are represented by six voting Board members. The Director of Strategy & OD and the Head of Fundraising also attend.

MEMBERS	DATE		
	9/5/13	12/12/13	6/3/14
Sarindar Sahota (Ch)	✓	✓	✓
Richard Samuda	A	✓	✓
Clare Robinson	✓	✓	✓
Toby Lewis	✓	✓	✓
Robert White#1	✓	✓	▒
Tony Waite#2	▒	▒	✓
Rachel Overfield#3	A	▒	▒
Colin Ovington#4	▒	A	A
Mike Sharon	▒	A	A

NOTES:

#1 Robert White resigned wef January 2014
#2 Tony Waite appointed as Director of Finance & Performance Management wef January 2014
#3 Rachel Overfield resigned wef September 2013
#4 Colin Ovington appointed as Chief Nurse wef December 2013

KEY:

✓	Attended
A	Apologies tendered
▒	Not in post or not required to attend

WORKFORCE & ORGANISATIONAL DEVELOPMENT COMMITTEE

Chair: Non-Executive Director

Purpose: To provide the Board with assurance concerning the delivery of the work programme and plans for implementing the Trust's Workforce & OD strategies (including strategic workforce planning, human resources management, learning and development and leadership development, to include the delivery of Trust's long terms workforce model.

Frequency: Four times per year

Membership: All voting Directors are Trustees, however they are represented by six voting Board members. The Director of Strategy & OD and the Head of Fundraising also attend.

MEMBERS	DATE				
	20/5/13	29/7/13	30/9/13	16/12/13	28/3/14
Harjinder Kang (Ch)	✓	✓	✓	✓	✓
Richard Samuda	A	✓	A	✓	A
Toby Lewis	✓	✓	✓	A	✓
Rachel Overfield#1	✓	A			
Colin Ovington#2				A	✓
Rachel Barlow	A	✓	✓	✓	✓
Mike Sharon	✓	✓	✓	✓	✓

NOTES:
#1 Rachel Overfield resigned wef September 2013
#2 Colin Ovington appointed as Chief Nurse wef December 2013

KEY:

✓	Attended
A	Apologies tendered
(shaded)	Not in post or not required to attend

CONFIGURATION COMMITTEE

Chair: Trust Chair

Purpose: The purpose of the Committee is to provide the Board with assurance concerning the strategic direction to support the project to establish the Midland Metropolitan Hospital (MMH) and that the programme of interim reconfigurations is consistent with the long term direction towards the new hospital. The Committee will focus specifically on the delivery of the MMH business case

Frequency: Alternate months

Membership: Three Non-Executive Directors, the Director of Strategy & Organisational Development, Chief Executive, Chief Operating Officer, Director of Finance & Performance Management and Medical Director

MEMBERS	DATE		
	15/10/13	12/12/13	28/2/14
Richard Samuda (Ch)	✓	✓	✓
Richard Lilford#3	✓	A	
Clare Robinson	A	✓	✓
Toby Lewis	✓	✓	✓
Robert White#1	✓	✓	
Tony Waite#2			✓
Mike Sharon	✓	✓	A
Roger Stedman	A	✓	✓

NOTES:

#1 Robert White resigned wef January 2014
#2 Tony Waite appointed as Director of Finance & Performance Management wef January 2014
#3 Richard Lilford resigned wef January 2014

KEY:

✓	Attended
A	Apologies tendered
(shaded)	Not in post or not required to attend

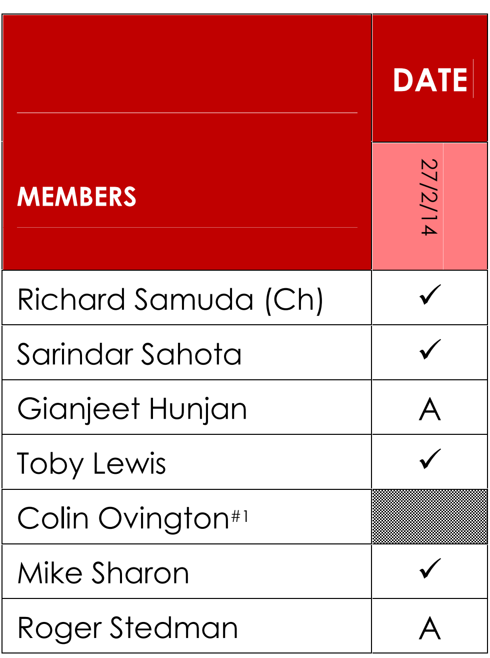
PUBLIC HEALTH, EQUALITY AND COMMUNITY DEVELOPMENT COMMITTEE

Chair: Trust Chair

Purpose: The purpose of the Committee is to provide the Board with assurance concerning the plans to improve the range and scope of whole life public health interventions from all areas of the Trust, including community & acute services and the delivery of the Trust's public health strategy.

Frequency: Quarterly

Membership: Three Non-Executive Directors, the Medical Director, Chief Executive, Chief Nurse and Executive Lead for Workforce



MEMBERS	DATE 27/2/14
Richard Samuda (Ch)	✓
Sarindar Sahota	✓
Gianjeet Hunjan	A
Toby Lewis	✓
Colin Ovington[#1]	
Mike Sharon	✓
Roger Stedman	A

NOTES:
#1 Colin Ovington appointed as Chief Nurse wef December 2013

KEY:

✓	Attended
A	Apologies tendered
(shaded)	Not in post or not required to attend

Sandwell and West Birmingham Hospitals NHS Trust

TRUST BOARD

DOCUMENT TITLE:	2013-14 Quality Account
SPONSOR (EXECUTIVE DIRECTOR):	Roger Stedman, Medical Director
AUTHOR:	Natalie Phillips/Roger Stedman
DATE OF MEETING:	5 June 2014

EXECUTIVE SUMMARY:

The Quality Account provides an overview of performance in 5 key focus areas for 2013-14 and a look forward to those identified for financial year 2014-15.

There is an emphasis on learning from the performance and taking that learning forward to enhance performance in the forthcoming year.

Throughout the report there are patient stories, scenarios and feedback that have been collated throughout the year. These provide us with the tools to monitor, assess and develop our services to be the best performing hospital we can be. We encourage the voice of our patients and employees to steer the Trust forward.

Also attached is the external audit opinion on the Quality Accounts.

REPORT RECOMMENDATION:

The Board is asked to accept the Audit & Risk Management Committee's recommendation to approve the Quality Account.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	x	

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	X
Clinical	X	Equality and Diversity	X	Workforce	

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

The Quality Account details the Trust's Quality priorities for 2014/15 and progress against those set for 2013/14.

PREVIOUS CONSIDERATION:

Audit & Risk Management Committee on 5 June 2014

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality Account 2013/14 – Draft 8

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Part 1: Chief Executive's Statement

To follow

Patient Story

"I had my mastectomy years ago at another hospital and I wasn't offered a reconstruction, but was given a silicon pad to use in my bra and give me back my shape. It wasn't until this starting leaking and I asked for a replacement that I heard that surgeons at City Hospital will do reconstructions. I was overjoyed when Mr Staiano offered one to me. At first my children were against the idea, because they thought I was too old, but I was determined and loved the idea of getting back into my bikinis and womanly lingerie. My treatment at City was first class and everything went so well. The nurses looked after me brilliantly on the ward, and Mr Staiano explained everything beforehand, and gave me a realistic idea of what to expect after the surgery. I am overjoyed with the result, and just can't wait for my next foreign holiday which I booked after my operation."

Introduction

Throughout the report you will find patients stories, scenarios and feedback that have been collated throughout the year. These provide us with some of the tools to monitor, assess and develop our services to be the best performing integrated Trust we can be. We encourage the voice of our patients and employees to help steer the Trust forward.

Within this section we review our performance for last year with particular reference to the key focus areas we identified in our Quality Account 2012/13. Where we have not succeeded in meeting our objectives we have set out an improvement plan and goal for this year.

There are a number of successes we would like to draw attention to:

- ✓ Our maternity services are to be congratulated for achieving the risk management standards required for CNST (Clinical Negligence Scheme for Trusts) Level 3. This is the highest level of risk management standard that allows us to give our maternity patients the assurance that they are cared for in the safest possible environment.
- ✓ We continue to make progress in reducing our mortality rates. This has been through a relentless focus on examining the causes of death through the mortality review system, where we have exceeded our target of reviewing 80% of all deaths in hospital. In addition we have improved our performance in the prevention of hospital acquired venous thrombo-embolism (VTE) by exceeding our target of 95% of patients being risk assessed.
- ✓ Significant work has been done with our partners to improve the processes around children's safeguarding, particularly in Sandwell.

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- ✓ Much work has gone into our role as a Health Promoting Hospital which has culminated in the soon to be published public health strategy for the Trust.
- ✓ There has been a very significant fall in the number of hospital acquired pressure ulcers. this is a result of a great deal of work by our nursing teams and tissue viability service.

There are also a number of areas where our performance is not where we would like it to be:

- ✗ We have had five never events, this is five too many. These are detailed below as well as our response to them. We will be reporting further on this in future Quality Accounts.
- ✗ There are two CQUIN areas where we failed to meet the targets we set ourselves. These are - The Safe Storage of Medicines, where repeated audits have shown we are failing to reliably lock away unused medicines - And - The Maternity Friends and Family Test response rate. We will continue to drive improvements in these areas even though they are not CQUINS again this year.
- ✗ A number of other key quality indicators are also below target - we have detailed these in the relevant sections and our plans to improve them this year.

Within this section you will also find our future goals, what we aim to achieve in 2014/15 and the processes in which we aim to deliver these.

We hope you find this to be an open and honest appraisal of our performance last year with areas of focus on our patients at the centre of our thought process for our next year of care.

Part 2 - Priorities for improvement and statements of assurance from the Board

2.1 Report on Quality Priorities for 2013/14

In last year's Quality Account, we identified five focus areas for prioritization. They sat within the 3 domains, patient safety, clinical effectiveness & positive patient experience which are identified in our Quality & Safety Strategy.

The focus areas were:

1. Continuing to improve the patient experience and safety in Emergency Departments (ED);
2. Reducing preventable deaths (Mortality);
3. Being a Health Promoting Hospital;
4. Reducing Emergency readmissions;
5. Patient Experience.

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Summary of Key Quality Achievements 2013/14

Focus Area 1 : Continuing to improve the patient experience and safety in Emergency Departments (ED)		
Aims	Actions	Did we do what we said we would do
Delivery of investment plans and recruitment in ED	Structural change to ED in order to improve flow and patient experience. Fully recruited to middle grades and nursing staff.	✓
Implementation of a new informatics system in ED	Implemented MSS Patient First IT system in ED.	✓
Development of our acute assessment and elderly care models in both hospitals	• altering our surgical flow • changing our elderly care ward model • introducing more step down capability for those patients requiring help to get home	✓
Establishment of joint health and social care team to include both Birmingham and Sandwell Social Services		✓
Improving the profile of discharges to precede admissions, ,	• building on the developments of the Transformation Plan with daily early senior ward reviews • transport and pharmacy projects to expedite early discharge	✓
Establishment of a 7 day capacity team with an Operational Centre to determine a better predictive emergency care flow and planning.		✓

Focus Area 2: Reducing preventable deaths (Mortality)		
Aims	Actions	Did we do what we said we would do
In 2012/13 we have increased the percentage of deaths that have been reviewed by senior doctors. However, we are committed to reviewing at least 80% of all deaths within 42 days of death	Increased the number of doctors conducting mortality reviews	✓
feedback to consultants regularly on deaths identified as preventable to aid lessons learnt	Held number of meetings and presentations of outcomes and Grand rounds	✓
Ensure that 95% of admitted patients have a VTE risk assessment carried out	Introduced mandatory use of electronic bed management system to carry out assessments before discharge	✓

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Carry out root-cause analysis of confirmed cases of hospital associated thrombosis	Conducted detailed review of all cases of hospital acquired thrombosis by quarter	✓
Set up a small, clinically-led group by the end of June 2013 to look at mortality difference	looking into deaths within the Trust and will identify themes which may need addressing to improve outcomes for patients	✓
We will improve our mortality performance to be better than the England average by March 2014	SWBH HSMR 2013/14 = 92.5 England average = 100.3	✓

Focus Area 3: Being a Health Promoting Hospital

Aims	Actions	Did we do what we said we would do
Submit a Health Improvement Strategy using the WHO HPH standards and local priorities from our partners by July 2013	SWBH is member of World Health Organisation (WHO) Health Promoting Hospital network. Membership allows SWBH to adopt best practices and share experiences with other Trusts.	✓
Develop an action plan from the Strategy and implement new health improvement activities in SWBH using specialist staff by September 2013	Develop an action plan in accordance with 40 HPH standards applied over 5 main domains – management policy, patient assessment, patient information, workforce health and community co-operation.	✓
Reinvigorate Health Improvement Training in the Trust including the Making Every Contact Count (MECC) programme, for all staff, focusing on stopping smoking, reducing alcohol consumption and making lifestyle preventive interventions for patients and employees by November 2013	Clinical Champion for Prevention and a Health Promotion Facilitator alongside a Prevention Steering Group. Links established with Public Health teams and the Health and Wellbeing Board in our locality and region. Health Promotion strategy using HPH standards has been developed addressing health inequalities.	✓
Formally adopt the principles of the Health Promotion Hospital network into our mission statement, policies and procedures by December 2013	We have fully achieved 30 and partly achieved 6 of the 40 HPH standards. We are still learning lessons on how to capture and evaluate health promotion interventions.	✓

Focus Area 4: Reducing Emergency Readmissions

Aims	Actions	Did we do what we said we would do
Put in place action plans to ensure that emergency readmission will be avoided	Taskforce Group has been established to address issues related to emergency readmissions.	✓
By March 2014 we will aim to meet the national mean for 30 day non-elective & 28 day non-elective readmissions in 2013	Scoring Tool adapted to identify patients who are likely to re-admit. Scores are based upon length of stay, acuity of admission, co-morbity and number of previous admissions.	Awaiting response from internal team

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By the end of June 2013, The Mortality & Quality Alerts Committee will develop and oversee an action plan to improve emergency readmission rates	Readmission Task Force has been established – collaboration between primary and secondary care in order to reduce the risk of readmission. This applies particularly in specialty areas such as cardiology, respiratory and elderly care.	✓
The Trust is also planning to review readmission rates of babies within 30 days, and will review current maternity bed capacity in line with Birthrate plus recommendations. This will be completed by March 2014, but is subject to business case approval in Spring 2013		✓

Focus Area 5: Patient Experience		
Aims	**Actions**	**Did we do what we said we would do**
Implement the patient experience Strategy as detailed in the implementation plan	Completed.	✓
Friends and Family Test milestone delivery	• Increasing the response rate in the acute inpatients and A&E areas. Achieving a response rate within the top 50% of trusts nationally, showing an improvement; • Phased expansion of the FFT to Maternity by the end of Oct 2013 and additional services by the end of March 2014; • Increase the FFT score within the 2013/14 staff survey compared to 2012/13.	✓ ✗ ✓
National and local patient survey to improve services based on the findings.	Completed the Inpatient Survey, A&E survey, Maternity Survey, Outpatient Survey, Cancer Patient Experience Survey and Chemotherapy Patient Experience Survey.	✓
Patient Engagement Programme	An ongoing programme of events built to expand and increase the opportunities available for regular patient engagement.	✓
Patient Stories	Patient stories collected as a learning tool for training and events as well as opportunity to share patient experience with the Trust Board.	✓
Volunteers	Overall number of volunteer recruits from a wide age group.	✓

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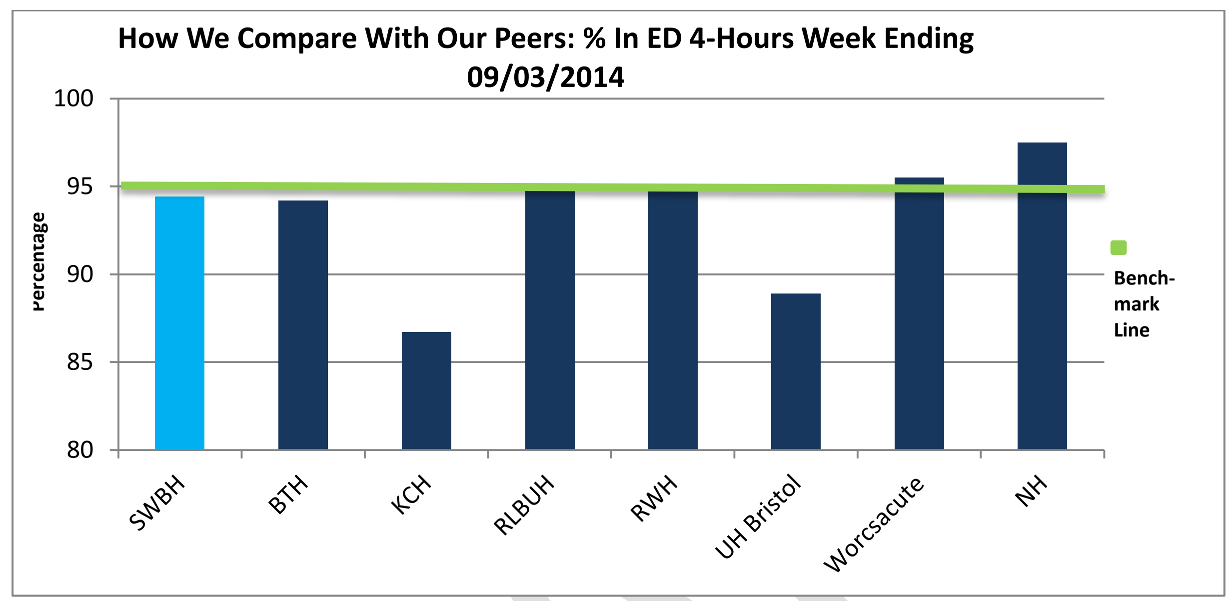
Focus Area 1- Continuing to improve the Patient Experience and Safety in Emergency Departments (ED)

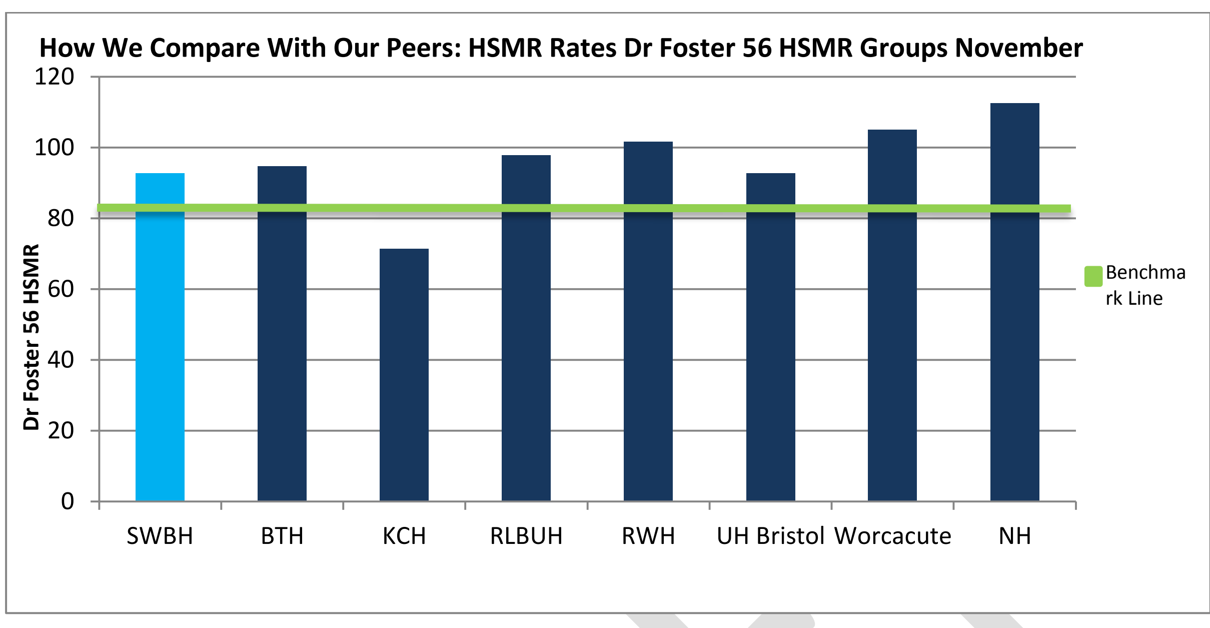


SWBH have a target of to ensure that 95% of our patients wait no more than 4 hours within Emergency Departments. We were able to achieve this target in 6 out of the 12 months and achieved an overall annual rate of 94.4%. The months where the target was achieved were June 13, August 13, November 13, December 13, January 14 and March 14.

In the summer of 2013, we launched the 'Winter Must be Better' (WMMB) 2013 Transformation Programme which encompassed a re-design of Emergency Care Pathways. The Patient experience in Winter 2012 had been poor with many patients waiting longer than 4 hours in the Emergency departments (ED), Ambulances frequently waited longer than 60 minutes to handover patients and those needing admission experienced long trolley waits due to a lack of beds on the Acute Medical Units. The WMBB 2013 Programme set out to establish a new service model which encompassed the establishment of dedicated Ambulance Assessment areas in ED and an increase in total funded medical beds from 452 to 494. The specialty allocation of the 494 beds changed from 60 - 120 Acute Medical Unit beds operating with a maximum length of stay of 48 hours and two dedicated nurse led Medically Fit for Discharge wards comprising of 48 beds.

Alongside the 'structural' service model changes all departments involved in the delivery of Emergency care engaged in new ways of working such as the rapid assessment of frail elderly patients in ED by therapies staff to prevent unnecessary admissions, the rapid turnaround of diagnostic tests in ED and acute wards, seven day working in Pharmacy and Radiology and weekend consultant reviews on the Acute Medical Wards. The Trust also introduced a Community Intravenous Antibiotic Therapy Service which both prevented admissions and enabled earlier discharges of patients.

Focus Area 2- Reducing Preventable Deaths



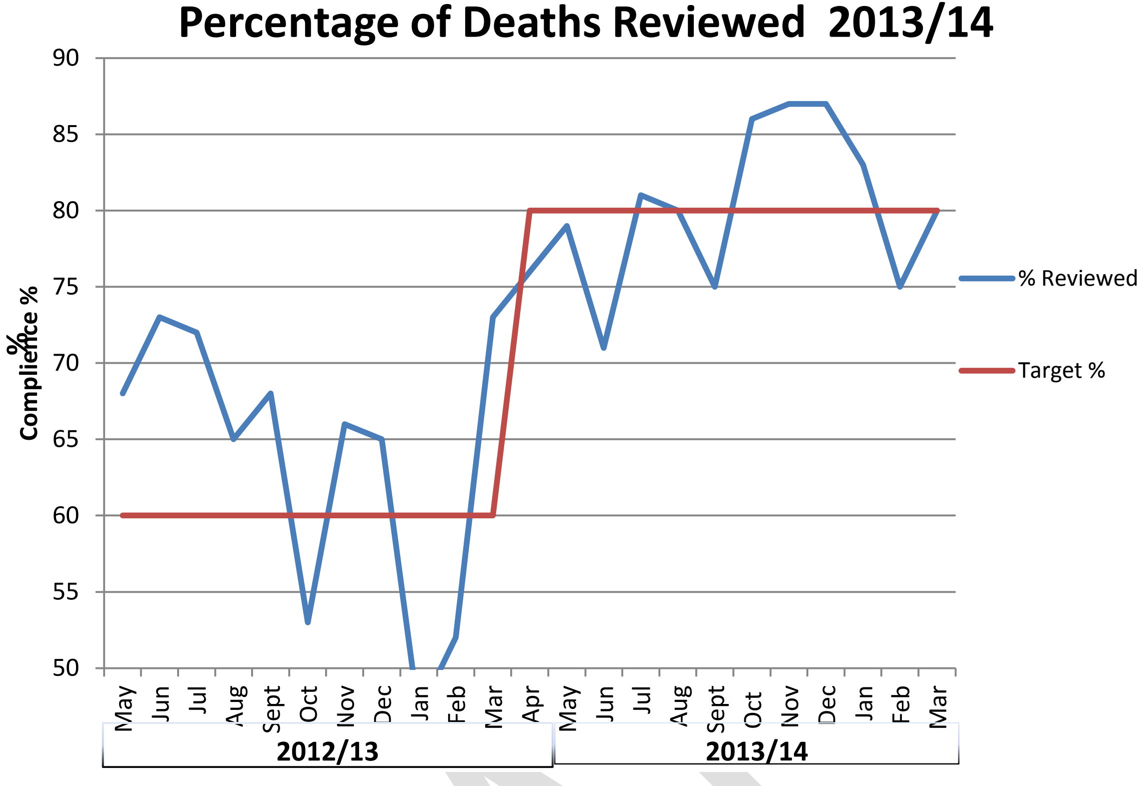
The improvements we said we would make were:

- Hospital Standardised Mortality Ratio (HSMR) - better than England's average.
    - SWBH – 92.1
    - West Midlands Average – 98.8
    - National Average – 100
- Over 80% of all deaths reviewed
- Feedback to Consultants – Lessons Learnt
- An investigation into differences in mortality between the two main hospital sites
- Improvement in risk assessment and prevention of hospital acquired venous thrombosis embolism (VTE)
- Conducted root cause analysis of all cases of hospital acquired VTE

Over 80% of all deaths reviewed

In 2012/13 we were successful in increased the percentage of Deaths that were reviewed by senior doctors to above 60%. However, we highlighted this as a continual high priority to improve further in 2013/14 and increased the target further to 80% of all patients were reviewed within 42 days of death.

We have continued to apply great efforts to achieving our motility goals and this has been demonstrated with our 82% annual compliance, further to that, quarter 3 alone saw a rise to 88.9% and Quarter 4 data awaited.



Use of Hospital Standardised Mortality Ratio (HSMR) & Summary Hospital – Level Mortality Indicator (SHMI)

We said we would use a range of tools to analyse mortality. We use HSMR and SHMI. It is reported every month to the Quality & Safety Committee, the Commissioners, and is discussed in detail at the MQuAC. We also carry out in-depth reviews of any diagnostic code that has shown that our incidence of disease seems to higher than expected.

HSMR is a standardised measure of hospital mortality and is an expression of the relative risk of mortality. It is the observed number of in- hospital spells resulting in death divided by an expected figure.

The Trusts 12-month cumulative HSMR (87.8) at the Trust remains below 100, and is less than the lower statistical confidence limit and continues to remain lower than that of the SHA Peer (96.7). The in-month (January 13) HSMR for the Trust has decreased to 81.4

The 12 month cumulative site specific HSMRs are 76.2 and 99.7 for City and Sandwell respectively, neither of which are currently in excess of upper statistical confidence limits.

Investigation into Differences in Mortality across the two Hospital sites

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As a result of the difference in mortality ratios between the main hospital sites, the Mortality and Quality Alerts Committee commissioned a 'Task and Finish' Group to examine the data behind this difference in more detail. The interim report details the findings from the work undertaken to date and it makes a number of recommendations including those to further the investigation going forward.

The HSMR at Trust level has (over recent years) been below than that expected. This is explained in part by City Hospital experiencing significantly less deaths than would be expected (according to Dr Foster's statistical methodology), whereas Sandwell Hospital has demonstrated a number of deaths in excess of that which could have been expected.

As a result of the difference in mortality ratios between the main hospital sites, the Mortality and Quality Alerts Committee commissioned a 'Task and Finish' Group to examine the data behind this difference in more detail. The interim report details the findings from the work undertaken to date and it makes a number of recommendations including those to further the investigation going forward. The below conclusion of the reports indicates the difference in ratio has many factors causing this.

- Risk adjustment relies on accurate coding of reasons for admission and co-morbidities. Detailed analysis demonstrates that our coding practice is not consistent between the two hospitals. Work is underway to improve this.
- Diagnosis on admission is not always the cause of death - we don't always have cause of death available at the time of review or coding.
- There are differences in case mix between the two sites, with Sandwell having a more elderly population and in addition hosting Trauma and Stroke services and City having a younger population but with a higher deprivation index.
- Coding for palliative care has increased in the last few years - this is due to the successful development of palliative care services. There are slight differences in the palliative care coding rates between the two hospitals - this impacts on HSMR but not on SHMI
- Our mortality review system has indicated a slightly higher number of adverse triggers for patients at Sandwell Hospital - this has not reached a statistically significant level, but could be suggestive of quality of care issues being a contributing factor. However the vast majority of deaths on both sites do not have any adverse triggers.

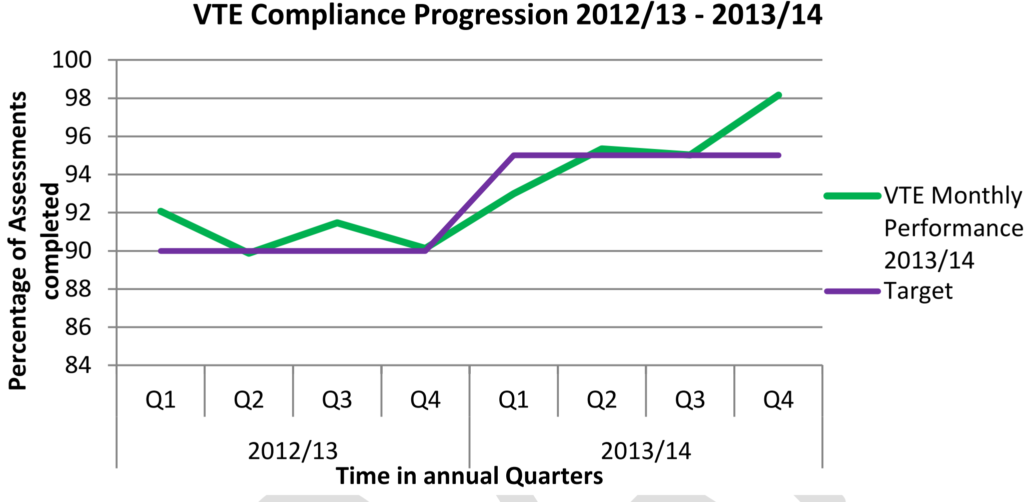
The work on site differences in mortality continues to form part of the mortality program this year.

Venous Thrombosis Embolism (VTE)

VTE is the term used to describe deep vein thrombosis (clots in the leg) and pulmonary embolism (where clots can break off and block the lung). This has long been recognised as a major problem that can affect patients whose mobility is impaired either by illness or following certain types of surgery. Doctors have, for many decades, included an estimate of

the risk of developing deep vein thrombosis in certain patients and provided preventive treatment where the risk was deemed to be high.

This CQUIN target has been carried on from 2010/11 thru 2012/13 but with a more stringent target of an assessment rate of 95% in admitted patients. The Trust met the 95% VTE target in 8 out of the 12 months. However, the 95% of admitted patients did receive a VTE risk assessment across the year. Over 98% was met consistently since December 2013, with significantly improved performance.



Root cause analysis of Hospital Acquired Thrombosis (HAT)

Over the past year we have identified the importance of identifying the root cause of patients with a Thrombosis to provide a scope for lessons learnt but also to identify how many patients' deaths were preventable. By establishing the preventable deaths we can recognise service areas for improvement along with reassurance that we are continuing to develop patient safety and provide best practice.

In quarter three of 2013-14 (October to December 2013), 45 cases of HAT were reviewed with 12 being proved to be preventable if more closer adherence was made to Trust policy. The remaining 33 cases were proved to be unpreventable.

We have made progress from a quarterly review of the root cause analysis as directed by Department for Health to a monthly consultant-led review as suggested by the All Party Parliamentary Thrombosis Group (APPTG).

Focus Area 3 - Being a Health Promoting Hospital

A Health Promoting Hospital is one which recognises its duty to engage with patients, relatives, staff, the membership group and wider local population to encourage health improvement. It demonstrates this by explicitly stating that Health Improvement is part of its mission, and by taking practical steps to make it happen. We have been engaged in this area for two years.

In September 2012 SWBH appointed a Clinical Champion for Prevention and in December of that year, SWBH joined the World Health Organisation (WHO) Health Promoting Hospital (HPH) network to build on the activities already taking place in the Trust.

What are the benefits of the WHO HPH network?

- Membership of this community gives an opportunity to discuss and compare different health improvement projects from hospitals and health systems worldwide, in order to see what works elsewhere and might be tried locally.
- The ability to use the WHO and HPH logos on internal and external documents to act as reminders of the international importance of prevention, and to help in raising awareness of these goals.
- In addition, the HPN publishes a list of 40 standards for a member organisation, applied over 5 domains to management policy, standard patient assessment, patient information, workforce health and cooperation with the community. We can use them to assess how well we compare in health promotion activities.

In the first domain, the WHO HPH standards require a mission statement, strategy and coordinating group to deliver a programme of awareness amongst all staff.

The mission statement is expressed in our Public Health Plan: 'We want to become renowned as the best integrated care organisation in the NHS, embedded in our local communities, not just as somewhere to be treated, but someone to be trusted – with health'.

There is a Clinical Champion for Prevention and a Health Promotion Facilitator at SWBH, and a Prevention Steering Group has been established with wide representation from across the health community. Links have been established with the Public Health Teams and Health and Wellbeing Boards in our locality, and with the SWB Clinical Commissioning Group. We have carried out engagement events with the Trust Leadership Meeting, Consultant Conference, with the Membership, and to the public at large at the Trust Board Annual General Meeting. A Health Promotion Strategy using the HPH standards and local priorities from the local health economy has been developed, with 13 major objectives covering clinical health promotion, addressing health inequalities and ensuring that we are mindful of our local community as we develop plans for a new hospital.

These standards also are explicit around routine assessment of patients' need for health promotion, how information is given to patients and to staff to help them improve their

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health, and that health promotion is written into job plans, patient pathways and departmental policies. Over the last year, based on audits of our processes, we have improved the prevention components of our clinical pathways and patient record documentation for our doctors, nurses and therapists to encourage them to ask about, and give advice on, health promotion to patients, visitors and staff.

Finally the standards require the hospital as an organisation to engage in health promotion throughout the local community. We have engaged with our Health and Wellbeing boards, set up community – based projects to increase local employment and access of our local homeless population to healthcare and improvement in the social determinants of their health.

What we have done as a Health Promoting Organisation in 2013-2014:

We have fully achieved 30 and partly achieved 6 of these 40 standards.
We still need to improve how we capture and evaluate health promotion interventions; further extend the health promotion components of our clinical pathways and ensure reassessment for health promotion at discharge. We need to engage our staff more in health promotion through induction and training to ensure that the majority are confident in advising and signposting colleagues, patients and relatives for further advice if required.

Several of the action plans will be implemented by specialist health promotion meetings which are already in existence: the Making Every Contact Count Implementation Group, Tobacco Strategy Meeting, and Alcohol Pathways Meeting. Reporting of the progress of Action Plans will be to the Public Health Community Development and Equality Committee which in turn reports to the Trust Board. The Prevention Steering Group will continue to meet to discuss and coordinate Health Promotion programmes, making wider links and informing the Public Health, Community Development and Equality Committee.
Progress will also be documented in the annual Quality Report, which is shared with the CCG.

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Patient Story

Jane suffered a traumatic start to December when she was admitted to City Hospital with chronic lung disease, needing three chest drains inserted.
"I was in such pain, every breath a battle. But, I felt like everyone had come to look after me, they weren't going to give up. They held onto my life. My condition worsened and I was blue lighted to Heartlands Hospital for emergency treatment. My doctor came with me and held my hand all the way. Even after I was discharged from City Hospital the support from staff on ward D17 didn't stop. They called me asking about my wellbeing and sent many get well soon messages. During the two weeks I spent in Heartlands Hospital, I remained in constant contact with my carers at City Hospital, calling everyday to come back to City and to D17. When I got to return to D17 and the doors opened and I saw all the staff it was very emotional. I just remember thinking 'thank you God'. D17 are my army, it's not just the staff here but all the staff behind them too, the care at City Hospital is a big jigsaw, all the pieces fit neatly together with no rough edges. D17 is a ward I trust, somewhere I feel safe. A ward that is committed to helping patients recover but always friendly and welcoming. The smiles are a big part of the recovery."

Focus Area 4 - Reducing Emergency Readmissions

We have developed a programme of work to support a reduction in re-admissions. This follows the analysis of data reviewing the high number of emergency re-admissions within 30 days to the Trust over a 3 year period. A Taskforce Group has been established to monitor and drive this key piece of work forward.

Development of the "LACE" Tool to identify patient at high risk of re-admission

We have developed a scoring tool to help identify patients who are likely to re-admit in real time, the tool known as LACE uses a scoring system based on L (length of stay), A (acuity of admission), C (Comorbidity), E (number of previous emergency attendances) this score produces an electronic symbol on the Trust's bed management system. Once fully developed the tool will consist of four components:

- An alert report showing patients with a high LACE score who are currently in-patients and those recently discharged
- A Symbol on the bed management system
- A discharge checklist to support patients Care Plan
- An alert to GP/Community services that the patient has been discharged with a copy of the discharge checklist

Communication flows between teams and board review meetings will be essential to ensure triggers alert appropriate specialities to initiate an MDT review. The tool is in the pilot phase and following analysis, we plan to roll it out to all wards across the Trust over the course of the next couple of months.

In support of this piece of work, teams in AMU are working on processes to improve care planning for patients with speciality teams at the beginning of their journey. By identifying patients likely to re-admit early on in the admission process, this will assist clinical teams to plan discharge, educate patients and carers to gain a better understanding of patients' medical condition and to aid patients in the self- management of their condition. This will also facilitate an early discharge where appropriate, back into a community setting without admission onto a main hospital ward. The discharge checklist will be signed off by senior decision maker and include planning with appropriate community teams to support patients' in their "home" environment. More intensive follow up will be required in community with follow-up phone calls and reviews in hot clinics as required.

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Patient Scenario
Barbara, a 74 year old lady was re-admitted 10 times in 11 months with all visits to A&E resulting in a stay overnight or admittance onto a medical ward. The lady lives alone, has a number co-morbidities and social problems. She has two daughters, one having just being diagnosed with breast cancer and the other has moved to another part of the country - her son assists her with shopping etc. To help support her situation the patient has recently moved into sheltered accommodation but has (to date) refused any kind of care at home although she would benefit from this. She is known to the community team and has had contact with community services on and off for the last couple of years, but still has multiple re-admissions. She has a history of psychoactive substance abuse and will use 999 as first point of call, especially if family are not around to support her.
This lady's case is being reviewed by the MDT team who oversee her care together with her family to help facilitate better support outside of the hospital environment.
Although the LACE tool will identify patients' who are likely to re-admit it will not facilitate a reduction in re-admissions on its own and there will need to be a re-design of processes, robust discharge plans and joint working with colleagues across the community including the voluntary sector and other groups such as West Midlands Ambulance Service to help support some of this work.
The speciality audits have started to inform some of the change that needs to take place, and has also highlighted other areas where changes in practice could improve quality of the Trust's data collection.

Supporting Work

- In addition to the LACE tool, a number of other key pieces of work will support the work programme:

- Work has begun to review of a number of ambulatory care pathways to reduce both the number of admissions and re-admissions and to facilitate a better patient experience.
- Acute Consultants and GP's are working together to create a new discharge summary. This will provide a greater in-depth summary and care plan to aid community teams with greater knowledge of the patient's admission so support can be offered to keep patients at home
- A Virtual Ward model is in the process of being developed by the Trust Community Admissions Avoidance Team who are working with colleagues in primary care to identify patients who would benefit from care within their own home instead of repeat admission to hospital
- A planned review of job plans to maximise Consultant led 'front door' early specialist input
- Expansion of antibiotic services and establishment of diuretic heart failure services
- Use of community teams to in-reach to support early discharge

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- Working with Clinical Teams to review completion of coding data and ensure patient episode are recorded against correct Consultant, to improve quality of data on transfer of care following “on-take”
- Pilot of an alert system to Care Home Teams when patients are admitted from Care Homes. This will help reduce numbers of re-admissions by facilitation of shared patient information and assist in either immediate discharge back to care home or early supported discharge
- Working with West Midlands Ambulance Service to reduce numbers of admissions for respiratory patients
- Development of information to raise awareness to staff in Trust of community services available to support patients in home setting and potentially reduce re-admissions
- Review of patients discharged at the end of the week with Social Care packages who were subsequently re-admitted revealed the need to develop referral into Palliative Care Pathways

Conclusion and next steps

The reduction of re-admissions is a complex and challenging area of work and involves all partner agencies in health and social care working together. The work will not only facilitate a reduction in re-admission rates but offer a better quality experience for patients and carers.
The work programme will expand over the next 12 months and will be supported by the development of another work programme looking at Long Term Conditions.

Focus Area 5 - Improving Patient Experience

We are committed to delivering the best possible experience of the services used by Patients, their families and their carers being mindful that this can only be achieved by ensuring this commitment is shared by everyone employed at the Trust.

To this end we have developed a strategy that brings together these simple truths based on an important belief: That our patients know best ie they have knowledge that we do not, because they know themselves better than we can.

We know that across the Trust there are areas where we achieve the best and others where we could do better We want the best of SWBH now to be what we do consistently across SWBH i We know that we don’t always get it right but it is our intention, to implement a culture where we continually listen and learn from patients, staff and carer feedback so that we work together to achieve sustainable service improvement and thereby the best deliver the best care possible.

We recognise that staff are our biggest asset and in order to deliver a good patient experience, we need to ensure a good staff experience. All staff have a responsibility to work within a way that ensures that ‘the patients voice is heard at every level of the

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organisation.' We expect staff to let us know when they feel unable to do this, either due to personal circumstances, lack of resources or inadequate systems and processes.

When a patient, resident, relative, carer, friend or visitor leaves a service we need only, simply, humbly and sincerely ask; 'Are you happy with the way you've been treated today?' and when we go home, ask ourselves; 'Is everything I've done today what I'd do for my family? 'To achieve this service delivery will focus upon the following key themes

- Give patients, carers and colleagues the same respect that we would want for ourselves or a member of our family
- Patients, their families and carers feeling informed, being involved and given options
- Staff who listen and spend time with their patient
- Being treated as a person and not a number
- The value of support services
- Consistent efficient processes

2.2 CQUIN (Commissioning for Quality and Innovation)

This part of the 2012/13 Quality Account is intended to provide additional evidence of our performance in respect of the quality of our services and the care delivered to our patients during the last 12 months. Most of the data presented here is available in other reports and documents, particularly in the Quality report presented to our Quality & Safety Committee and at our Trust Board throughout the year. The detail behind many of the figures has been reviewed by our commissioners and other stakeholders and the most critical indicators are discussed with our commissioners during monthly Quality Review Meetings, which also explore specific issues or concerns arising throughout the year.

CQUIN performance 2013/14

The 2013/14 CQUINs agreed were as followed, the CQUIN contract value was £8.970m. As a result of not achieving and delivering Medicine Management, FFT roll out in Maternity and Sepsis bundle use, the total of withheld funding was £0.9105m. These non-achieving areas are explained below table. Final data is awaited for the following schemes; VTE RCA, Staff FFT, Use of Sepsis Care Bundles and Recording DNAR Decisions.

		Measure	2013/14
	Commissioning for Quality & Innovation (CQUIN)		
National	**VTE Risk Assessment (Adult IP)**	%	**98.7**
National	**VTE Root Cause Analysis**	%	**100**
National	**NHS Safety Thermometer - Reduction in Pressure Sores**	No.	**On Track**
National	**Dementia - Find, Investigate and Refer**	No.	**Met**
National	**Dementia - Clinical Leadership**		**In Place**

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National	Dementia - Supporting Carers of People with Dementia		Monthly Surveys in Place
National	Friends and Family Test - Phased Data Collection Expansion	%	16.4
National	Friends and Family Test - Increase Response Rate (Emergency Care and Wards)	%	20.3
National	Friends and Family Test - Improve Performance on Staff FFT	Score	
Local	Safe Storage of Medicines	%	81
Local	Dementia Patient Stimulation		In Place
Local	Use of Pain Care Bundles	%	Met
Local	Use of Sepsis Care Bundles	%	Met
Local	Community Risk Assessment & Advice	%	Met
Local	Recording DNAR Decisions	%	On Track
Specialised	Clinical Quality Dashboards		Fully Compliant
Specialised	Bechets Highly Specialised Service		Fully Compliant
Specialised	HIV - Communication with GPs		Fully Compliant
Specialised	Neonatal - Retinopathy of Prematurity Screening	%	Met

Key Performance Indicators 2013-14

These are a list of areas we have set ourselves to improve upon, these are reported at the beginning of the year and monitored throughout the year. They have no financial implication attached to them however hold great importance to achieve.

	Measure	2013/14
Access Metrics		
Cancer - 2 week GP Referral to First Outpatient	%	95.0
Cancer - 2 week GP Referral to First Outpatient (Breast Symptoms)	%	96.7
Cancer - 31 day Diagnosis to Treatment for All Cancers	%	99.2
Cancer 62 day Urgent GP Referral to Treatment for All Cancers	%	87.0
Emergency Care 4-hour waits	%	94.5
Referral to Treatment Time - Admitted <18 weeks	%	91.5
Referral to Treatment Time - Non Admitted <18 weeks	%	96.8
Referral to Treatment Time - Incomplete Pathway<18 weeks	%	93.4
Acute Diagnostic Waits >6weeks	%	0.81
Cancelled Operations	%	1.1
Cancelled Operations (breach of 28 day guarantee)	%	0.020
Delayed Transfers of Care	%	3.1
Outcome Metrics		
MRSA Bacteraemia	No.	1

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C Diff	No.	39
Mortality Reviews	%	80.0
Hospital Standardised Mortality Rate	HSMR	92.1
Summary Hospital-level Mortality Index	SHMI	100.1
Caesarean Section Rate	%	24.9
Patient Safety Thermometer - Harm Free Care	%	94.4
Never Events	No.	5
VTE Risk Assessment (Adult IP)	%	98.7
WHO Safer Surgery Checklist	%	99.9
Quality Governance Metrics		
Mixed Sex Accommodation Breaches	No.	124
Patient Satisfaction (FFT) - Response Rate (IP Wards and Em. Care)	%	20.3
Patient Satisfaction (FFT) - Score (IP Wards and Em. Care)	No.	60
Staff Sickness Absence	%	4.33
Staff Appraisal	%	96.7
Medical Staff Appraisal and Revalidation	%	97.0
Mandatory Training Compliance	%	86.6
Clinical Quality & Outcomes		
Stroke Care - Patients who spend more than 90% stay on Stroke Unit	%	91.3
Stroke Care - Patients admitted to an Acute Stroke Unit within 4 hours	%	76.4
Stroke Care - Patients receiving a CT Scan within 1 hour of presentation	%	71.9
Stroke Care - Admission to Thrombolysis Time (% within 60 minutes)	%	51.2
Stroke Care - Swallowing Assessments within 24 hours of admission	%	98.6
TIA (High Risk) Treatment within 24 hours of presentation	%	70.9
TIA (Low Risk) Treatment within 7 days of presentation	%	84.5
MRSA Screening Elective	%	92
MRSA Screening Non Elective	%	94
Inpatient Falls Reduction – Acute	No.	607
Inpatient Falls Reduction – Community	No.	119
Hip Fractures - Operation within 24 hours	%	70.3
Patient Experience		
Complaints Received - Formal and Link	No.	948
Patient Average Length of Stay	Days	3.7
Coronary Heart Disease - Primary Angioplasty (<150 minutes)	%	92.5
Coronary Heart Disease - Rapid Access Chest Pain (<2 weeks)	%	95.7
GU Medicine - Patients Offered Appointment <48 hours	%	100

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2.3 Non –achieved Goals

It is important for us to share with the public, our failures as well as our accomplishes to give an honest overview of our hospital, but also to show you were we need to put oiur focus on for the next year. Below are the non-achieved CQUINS and Key Performance indicators explaining how the failure has occurred and what plan we have actioned to improve through the next year.

Non-achieved CQUIN

Medicine management

In 2013/14 we saw the protocols were not followed by all employees resulting in the performance being 9% lower than the 90% needed.

Although this will not continue forward into 2014/15 as a CQUIN, we hold this as great importance in the professional Nursing role and will continue to monitor with spot checks on a weekly basis. Where required, we will hold staff to account, going through the disciplinary process as a consequence of not following our policies on medicines management and in particular to the safe storage of medicines.

FFT roll out in Maternity

Friends and Family Test (FFT) is dependent on new mothers completing and returning a postcard with their views on once discharged and at home with their new born baby. We are aware that the new parents are unlikely to fill this postcard in therefore we have looked into new ways of getting this data fed back.

We are currently in the process of trying to get the FFT installed on ipads for community midwives to have instant information on midwife visits. We are currently working through a number of information Governance issues before this can take place.

Non-achieved Key Performance Indicators (KPI's)

Emergency Care 4-hour waits
The trend of underperformance that emerged in 2012/13 continued into 2013/14. During the year a significant pathway reengineering programme (initially entitled Winter Must Be Better) was implemented, which led to the creation of a new model of emergency care (ED pathways and revised principles for assessment units), as well as new areas dedicated to the care of patients who were medically fit for discharge but remain within the acute trust.

Supporting this was the development of an operations centre allowing for greater coordination of patient moves across the Trust. Performance trajectories were agreed with the CCG and the LAT and this was intensively monitored on a weekly basis by the chief officers of the groups concerned

Cancelled Operations
Cancelled operations remain an area of concern. During the year 2013/14 we instituted tighter controls around theatre utilisation, whereby session utilisation and throughput are reviewed on a weekly basis and list sizes amended to ensure sessions run to time, however regrettably, cancellations still have occurred. In addition, better control over bed flows via the Capacity Management team has meant that late notice cancellations due to 'no bed' should be reducing. For this financial year, the Clinical Groups are focused upon improving theatre utilisation and reducing cancellations as part of their efficiency improvements.

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Cancelled Operations (breach of 28 day guarantee)
The process for checking the potential 28 day breaches and ensuring that they are booking within the agreed time was revised during the year following the (retrospective) emergence of some breaches. This has been revised again in 2014/15 following a further breach of this guarantee, in response to the root cause analysis and the identification of a further system weakness.

MRSA Bacteraemia
The majority of the attributable MRSA bacteraemias for 2013-2014 were due to skin contaminants from blood cultures taken in Emergency Departments (ED). We aim to reduce these numbers by organising urgent training of ED nurses to enable them to take blood cultures effectively.

Never Events
Last year we reported 5 never events, including one from the previous year; as a trust this has caused grave concern and a patient safety conference was called for all senior clinical leads and managers to attend. Section 3.5 goes into detail of the individual never events, the learning and actions to go with these and our focus to improve on this for 2014.

Mixed Sex Accommodation Breaches (MSABs)
Under-reporting of MSABs was identified during 2013/14 with regards to the nature of the exceptions that had been built into the reporting system. In particular around declaring patients who had stepped down from level 2 or 3 to level 1 but remained on a mixed sex unit. The policy was amended and we have recently implemented a new electronic tracking system to track gender bed allocation.

In parallel we have tightened our processes on the stroke unit to ensure that patients are reviewed and stepped down from level 2 to level 1 much quicker in their pathway. This transition has led to an unanticipated increase in mixed sex breaches as these patients remained in level 2 areas when they were level downgraded to level 1 care, on our stroke unit. The Trust has this performance area as a significant focus. We are reviewing bed flows and capacity on the stroke units to accommodate this and auditing the new procedures.

Staff Sickness Absence
We have not me the local goal set of 3.15% sickness however we have achieved our trust goal, we have identified key areas of improvement and areas of further audit.

Mandatory Training Compliance
NHSLA standards for level 3 state that where an audit is conducted and risk management (mandatory) training compliance is more than 75% but less than 95%, then an action plan should be in place to improve the level of compliance with an aim to achieving 95%. We are a level 2 organisation but I wanted to stretch the compliance target to achieve level 3 standard.

In 2012/13 we conducted such an audit and found compliance to be around 78%. Over the last 12 months we have managed to increase compliance to 87% which is very positive. The target of 95% is idealistic and unlikely to be achieved due to sickness absence, staff turnover, maternity leave and other operational factors. However, in 2014/15 we will review the risk management TNA and try to reduce the mandatory training liability thus potentially increasing the likelihood of improved compliance.

Stroke care – admissions to acute stroke unit within 4 hours
In some months of 2013/14 we have not been able to meet this target which relates to the increased number of stroke admissions, together with difficult discharge of some of the complex stroke patients. Despite this, our overall performance of 76.4% has been one of the best in the country, compared to the overall of 51.2% nationally.

We plan to address this to streamline the Stroke Pathway and remove all bottle necks with the following measures:

- 2 beds to be kept free at any time – 1 of these beds to be a side-room to ensure timely admission of stroke patients from ED to the stroke unit.
- Continue Board rounds every morning and invite the ESD (Early Supported Discharge) team to attend once weekly. This should help identify plans to ensure two beds are free and also identify patients who could be discharged early with rehabilitation at home.
- When there is no identified plan and/or when only one bed available, the Ward Co-ordinator will now alert Consultants and Matron
- To improve earlier recognition of stroke and quicker transfer we are currently exploring the possibility of the routine stroke being scanned and clerk and transferred directly to the stroke unit
- Group establishing in June 2014 to address the complex discharge for the cohort of patient with increased length of stay

Stroke Care – Admission to Thrombolysis Time (% within 60 minutes)
In November 2013 , we established a negative impact of the target with Emerganct Departments. Meeting were held throughout December and the Stroke Pathway was changed to visualize a better incorporation of all services to be more efficient and timely for the patient, including colleague in ED and imaging. This has had great impact of the patient care in our emergency Department and we have increased our thrombolysis rate to more than 13% of our stroke patients. We achieved more than 95% less than 60 minutes and in fact, most of our patients were thrombolysed less than 45 minutes. We hope that in 2013/14 we can share a 95% achievement across the year.

Hip Fractures – operation within 24 hours
The National guideline for Fractured Neck of Femur (#NOF) best practice tariff is 36 hours. We try our best to take the patients to the theatre as soon as possible as #NOFs are our priority. The target of 24 hours is a locally agreed target with CCG 3. This target is 80% to allow for patients coming before 9am which have a high risk of 24 hour breach unless we can take them to theatre the same day, which is not always possible. In addition some

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patients may not be immediately fit for surgery within 6-8 hours of admission. Our bar has been set much higher compared to National guidelines.

This has been further complicated by the fact that in 2013/14 we have also seen a substantial rise in the volume & complexity of patients coming through our emergency department with hip & other types of fractures. Some of these also need priority surgery.

Actions undertaken:

- We have now extended our trauma clinic from 9am-5pm, every day, including weekends.
- NOF is always a priority (open fractures - children - #NOF - then any other fracture).
- We have a live NOF database & BPT dashboard to analyse every breached patient. Trying to identify trends, if possible to pre-empt.
- We have dedicated Anesthetists for the whole week now, who assess #NOFs as they are admitted to bring them to theatre ASAP.
- Ortho-geriatrician assesses every NOF as soon as admitted to make them fit as soon as is possible.

Possible Options:

- Dedicated #NOF lists every day, which will need additional trauma theatres to accommodate all other fractures.
- Extend trauma list in the evening till 8pm.
- Creating extra trauma theatres at short notice when volume is high.

Coronary Heart Disease – Rapid Access Chest Pain (<2 weeks)A shortfall of three consultants resulted in an overwhelming capacity on the remaining service providers. Although Rapid Access Chest Pain (RACP) clinics were maintained during this period the demand for these was not met in a timely way by the capacity which was available.
To rectify this, the three vacant posts have now been appointed to and from April 2014 are all within the Trust providing care. We will be able to offer an additional RCAP Clinic to improve the throughput of cases.
Although the process by which we monitor and escalate RACP cases which are of potential long waits has been assessed and improved. Further work has been outlined to analyse the type of cases which are referred to us, ensuring our patients are being seen through the optimal pathway.

2.4 How we decided on the priorities for our Quality Account for 2014/15

Our priorities for 2014/15 are informed not only by our long term quality goals but also through extensive consultation with our patients, staff, local commissioners, health and wellbeing boards and also national priorities.

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We have sought the views of patients through our member's events throughout the year – including the sharing of the draft public health strategy, consultation on our quality priorities and gaining feedback on the success of the reconfiguration of stroke services.

We have engaged with staff through regular staff forums such as our monthly Hot Topics meetings, feedback from our annual general meeting, leadership conference and consultant conference.

We work in close collaboration with our principle commissioners – Sandwell and West Birmingham CCG – with whom we agree our CQUIN (Commissioning for Quality and Innovation) targets for the year and service development improvement plans.

In March this year we met with the Birmingham Overview and Scrutiny Committee and shared with them our quality priorities for the next three years.

We have collated information and feedback from all of the above and selected the following areas for focus in 2014/15:

1) Reducing emergency re-admissions
2) Reducing preventable deaths
3) The patient Experience in Outpatient departments
4) Publication and implementation of the first year of our three year public health strategy
5) Improving the safety of patients in hospital through our 10/10 campaign

2.5 Priorities for Quality Improvement in 2014/15

Focus Area 1- Reducing Emergency Readmissions

We have selected this area for focus again this year because our emergency readmission rates remain high compared to national average. A great deal of work has been done in this area over the last year – mainly in advancing our understanding of reasons for readmission.

This year we intend to implement the learning from this in particular we will be:

- Embedding the use of the electronic LACE tool and other predictors of readmission to target interventions aimed at reducing the risk of readmission.

- Improving the quality and timeliness of information provided to GPs following discharge from hospital by improving our discharge letter process.

- Implementation of evidence based discharge bundles for patients with Respiratory disease and Heart Failure.

- Improving rapid access to specialist advice in respiratory and cardiac disease through the increase in rapid access clinics and emergency ambulatory care pathways

Patient Story
"Don was making a pot of tea when he suddenly stopped and grabbed hold of the worktop. I knew there was something really wrong when I couldn't get a response from him. When I managed to sit him down, he just slumped off the chair. Our local hospital doesn't have an out of hour's emergency service, so the paramedics bought us to Sandwell Hospital where Don received the treatment which saved his life." Donald is now up and about and has moved to the stroke rehabilitation ward where his is receiving treatment from occupational and speech and language therapists.

- Improving specialist advice at the front door through initiatives such as 'Cardiologist in AMU' and the 'Front Door Geriatrician'.

- Improving integration of hospital, ambulance, primary care and community teams – with a system of alerts for patients at high risk of readmission.

- Conducting an audit into the 'Last year of Life' looking into reasons for multiple admissions to hospital towards the end of life.

Through this program of interventions we intend to reduce the emergency re-admission rate by 1% - which will bring us in line with other acute trusts.

Focus Area 2- Reducing preventable deaths (Mortality)

The importance of our mortality rates as an indicator of quality of care means that we have to continue to keep this as one of our top priorities. We are amongst the best Trusts in the West Midlands for our mortality rates – however there is much we can do to get closer to the best in the country.

In 2013/14 our cumulative HSMR was 92.5% – this puts us above average, however we want to be in the top quartile (the best 25%) in the country. We will do this by the following:

1) Improving our mortality review system with the aim of reviewing 100% of deaths within 42 days by the end of the year.

2) Improving the lessons learnt by taking part in and incorporating some of the methods from the PRISM2 study into the mortality review system.

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3) Investigating differences in mortality between the weekend and week days and improving seven day services.

4) Improving the process of death certification and referral to the coroner. An electronic system for referral and recording of death.

5) Introduction of VitalPAC – the electronic recording and monitoring of patients vital signs. All adult acute wards will have VitalPAC by September 2014.

6) Continuing with the work to improve the recognition and response to the patient with sepsis. Increasing the percentage of patients screened positive for sepsis receiving sepsis six bundle to 50%.

7) Improving the prevention of hospital acquired venous thromboembolism (HAVTE) – improving risk assessment, prophylaxis and conducting root cause analysis on all cases of HAVTE. More than 98% of inpatients will be risk assessed.

Focus Area 3- Year of Outpatients

The purpose of the Year of Outpatients is patient care; we want at least 98% of our patients to tell us that their outpatient experience was outstanding. We have set ourselves a programme to design a better experience for patients, staff and carers. We are trying to create an expectation from our patients for an experience which gives timely and well informed care. In particular we aim to achieve:

- Letters sent to patients within 5 days;
- Hospital led cancellation of appointments will be a rarity;
- Patients will be informed that we have received their referral.

We will have a personalised way of undertaking outpatient care, the eight standards need to be met and patients are happy with the services we provided. The standards will become compulsory by March 2015. The programme, which will commence in May 2014 will be chaired by the Chief Executive with a fortnightly board meeting to measure the progress. A weekly Chief Operating Officer delivery group meeting will take place on a weekly basis and directorate will be reporting on a quarterly basis against the standards set from June 2014.

Focus Area 4- Public Health Implementation

Our Trust is a very large employer, and many of our employees and patients live locally. We spend more than £80m a year on resources and services, and many of those are bought locally and sustain local employment. We know that one of the top roles that we can play in local health is by helping with employment as we know the next few years could see turbulence in public service jobs. Our Public Health Implementation Plan commits us to working with our employees to ensure that they too have access to the best health advice, and are supported by their peers and employers to achieve the difficult jobs we do.

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Public Health Objectives

Objective No.	Definition
Objective 1:	80% of Trust staff to be trained in Making Every Contact Count and confident in making very brief interventions
Objective 2:	For all pregnant women to receive carbon monoxide monitoring and, as required, intensive smoking cessation support
Objective 3:	All of our community nurses, and nurses working for others in the community, to be delivering audited asthma advice to prevent acute admissions and to improve self-management habits
Objective 4:	All Trust sites to be smoke-free by 2018, supported by an extensive and effective programme of cessation advice and Nicotine Replacement Therapy for both staff and patients
Objective 5:	Reduce alcohol related admissions by at least a fifth against 2013-14 baseline, with a 50% increase in referrals from the Trust to partner alcohol support agencies by the end of 2015
Objective 6:	The Trust can evidence that the food we serve and others serve on our sites actively and successfully promotes healthy choices, appropriate portions, and is consistent with nutritional advice
Objective 7:	All new employees joining our Trust, and existing staff who choose to do so, will provide health data to us, which we will use to offer tailored support with risk issues including weight management, smoking, and alcohol consumption.
Objective 8:	We will deliver our 'strand one' health promotion priorities, including extensive Nicotine Replacement Therapy for staff, gym facilities on our Sandwell site, and out of hours access for night-workers to healthy food options
Objective 9:	We will be recognised as a leader in workplace mental health provision and support for our teams. This will support our drive to cut sickness absence below 3%.
Objective 10:	Our Trust is recognised as the youth employer of choice in our region, because we have doubled the number of apprenticeships we offer and have a work experience programme embedded in all local schools
Objective 11:	The Trust tackles the number one priority of local Health and Wellbeing Boards by delivering outstanding services for homeless people in partnership with the third sector and others - both as a care provider and as an employer
Objective 12:	We will select our new hospital partner in accordance with our regeneration obligations, and will shift by at least 10% the proportion of type B goods and services purchased locally
Objective 13:	We will deliver our sustainability action plan, which will cut landfill use by 5% and stabilise our energy usage at current levels, and therefore improve our NHS good corporate citizen assessment score by 10% or better

What we plan to do & how we will measure and monitor our progress

- Formally launch the Strategy as 'Our Public Health Plan' by June 2014; and continue high-profile information campaigns around Health Improvement in our communities.

- Develop and implement action plans for each of the 13 objectives in the Plan and implement new health improvement activities in SWBH across all the domains of the

Health Promoting Hospital Standards

- Promote Health Improvement Training in the Trust including the Making Every Contact Count (MECC) programme, focusing on giving staff the skills in very brief interventions for stopping smoking, reducing alcohol consumption and making lifestyle preventive interventions for patients and employees. We intend all staff to be aware of the programme and 80% of public-facing staff to be confident in advising, signposting and making these very brief interventions.

- With our partners in Public Health Departments, implement an integrated information technology support system across the Trust's computers to assist in staff training in Health Promotion and referral of patients and relatives for formal smoking, alcohol, and lifestyle counselling.

- To offer and support lifestyle services to our patients, staff and the wider local community in partnership with other agencies and organisations.

- Formally adopt the principles of the Health Promotion Hospital network into our Trust's mission statement, policies and procedures by December 2014.

- Make contacts with other organisations locally, nationally and internationally to further develop our reputation and capability in Public Health.

Focus Area 5 – Safety 10/10 Implementation

Ten out of Ten Safety Standards

During 2014/15 we will implement a programme aimed at ensuring that we do everything possible to prevent harm being experienced by any patient. The 'ten out of ten' approach is focused on the ten things we should do for every admitted patient, if these are completed we improve the individual patients experience throughout their stay with us. We want patients to know about these standards and will be placing a copy beside every bed in our hospitals and inform patients about them in our communications with them.

	Ten out of Ten Safety Standards
1	We will use Positive patient identification using three unique identifiers
2	We will assess every patient for their risk of developing a pressure ulcer and put in place the appropriate preventative measures
3	We will assess every patient for their risk of falling and ensure that the correct preventive measures are in place

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4	We will assess every patient for the risk of developing venous thrombo-embolism and ensure the correct prophylaxis is prescribed where appropriate
5	We will ensure every patient has a base line set of observations carried out by a registered nurse including at least one record of height and weight
6	Every patient will have their medicines checked and reconciled against a definitive list and have any allergies clearly documented on their prescription chart
7	Every patient will have their mental capacity assessed and where required referral for further assessment
8	Every patient will have their pain assessed against a visual analogue scale and offered analgesia if required
9	Every patient will be screened for MRSA and give decolonisation treatment if required
10	Every patient will have their nutrition and fluid needs assessed and given access to appropriate nutritional advice

2.6 Goals agreed with Commissioners for 2014/15

Use of the CQUIN payment Framework

The Trust has been working closely with the commissioners to develop a whole raft of quality schemes which are summarised in the table below. They are a combination of national and local priorities and some of them are highest priorities and have been described in more detail at the beginning of our Quality Account.

CQUINs 2014/15

Goal	CQUIN Goal Name	Description of Goal	Quality Domain
1	Friends and Family Test	Implementation of staff FFT and early implementation to patients. Increase the response rate within the trust and reduce the negative responses received from both patients and staff.	Patient Experience
	NHS Safety Thermometer	The number of patients recorded as having a category 2-4 pressure ulcer (old or new) as measured using the NHS Safety Thermometer on the day of each monthly survey	Patient Safety
2	Dementia	Improve early assessment, referral and treatment of dementia with a viable support system for carers of people with dementia. Clinical leadership in dementia to be further development.	Clinical Effectiveness

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3	Learning from Safeguarding Concerns	To ensure safeguarding practices support the needs of vulnerable children and adults. To ensure that providers continue to embed safeguarding into practice, implement lessons learnt following a safeguarding event, reflect on practice and ensure voice of adult/child is heard	Patient Safety
4	Outpatient and Discharge Letters	Assess the quality of outpatient and discharge letters to ensure high care quality is maintained when in communication between health care providers. Reducing the likelihood of omissions of vital importance such as new or altered medical treatments.	Patient Experience
5	Sepsis	Reducing mortality due to sepsis	Patient Safety
6	Pain Care bundles	Decide what the pain review process will be at ward specific or clinical pathway level. Write down and agree it across the team (using the method of asking patients to describe their pain level on a scale of 0 to 10 at agreed pathway intervals) Measure how many patients receive it. Objective: Eliminate pain review process that leads to variation in patient experience of pain relief.	Clinical Effectiveness
7	Medication & Falls	The cause of a fall can be complex; however the association between drugs and falls has been widely studied, with increasingly robust evidence of a causal link. Both specific classes of drugs and the total number of drugs taken are associated with falls. This CQUIN aims to raise awareness of, and examine what actions, can be taken to prevented falls through multifactorial interventions - focusing on the impact of medications.	Patient Safety
8	SUI assurance (including Never Events)	Through clinical audits - assurance that low compliance and poor audit result areas are being actioned by the Trust. Evidence of improving the approach to share learning across departments.	Patient Safety
9	Community Therapies referral	Effective referral management across community services.	Patient Safety

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	to treatment		
10	Implementing unified assessment criteria to support equitable access and informed choice for place of birth.	Evidence that women deemed low risk are having low risk births at time of delivery.	Patient Experience

Specialised Services CQUINs

	Service	
1	Behcets clinical outcomes collaborative audit meeting	Providers of Highly specialised services will hold a clinical outcome collaborative audit workshop and produce a single Provider report.
2	HIV home delivery	Establish the national baseline for home delivery of HIV medicines and to expand this to a minimum of 70%
3	Neonatal retinopathy of prematurity screening	To achieve an increase in screening to a target of 95% of babies with a birth weight of <1501g or a gestation of <32+0 weeks who undergo 1st Retinopathy of Prematurity (ROP) screening whilst still an in-patient and screened 'on time'.
	Neonatal parenteral nutrition	During early postnatal life, the nutritional needs of preterm infants are usually met through parenteral nutrition. This indicator aims to improve the proportion of preterm babies who start TPN by day 2 of life. It excludes babies who undergo surgery on day 1 or 2 of life.
	Existing specialised services dashboards	This indicator is aimed at ensuring that Providers embed and routinely use the required clinical dashboards developed during 2013/14 for specialised services. The Area Team is responsible for agreeing the relevant dashboards with the providers.

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2.7 Statements of Assurance from the Board

Statement of Directors responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009

and the National Health Service (Quality Accounts) Regulations 2012 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The quality Account presents a balanced picture of the trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable and conforms to specified data quality standards and prescribed definitions, and is subject to scrutiny and review; and
- The Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief that the have complied with the above requirements in preparing the Quality Account

By order of the Board-

…………………………..Date ………………………………………………………….Chair

…………………………..Date ………………………………………………………….Chief Executive

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Review of Services

During the period 2013/14 the Sandwell and West Birmingham Hospitals NHS Trust provided and/or subcontracted 46 NHS services.

The Sandwell and West Birmingham Hospitals NHS Trust has reviewed all the data available to it on the quality of the care in 46 of these services. Where the trust has subcontracted any activity, it would only be to a provider which was registered with the CQC. Agreements between the Trust and the subcontracted providers require that the same high standards of care given by SWBH are maintained when giving care on our behalf. The health benefit and activity data undergo the same level of scrutiny as that delivered in the Trust.

Patient Story

"I came into A&E at the Midlands Eye Centre on a Friday evening with the news that they didn't think there was a particular problem with my eyes, but it was the rest of my body! I received a call from Prof. Murray's secretary on the Monday morning inviting me to clinic that afternoon where I was diagnosed. By having potentially serious eye involvement and happening to present to one of the leading Ophthalmologists in Behçet's, I received a very prompt diagnosis. Since my diagnosis with my eyes, I've also suffered with joint pains, ulcers, headaches, pathergy reactions and ulcers along my bowel and in my genital area in addition to the chronic fatigue that comes with any long term condition. I consider myself really fortunate though, as I've had a great team of consultants managing my care from day one including ophthalmologists, rheumatologists, oral specialists, gynaecologists and occasionally neurologists and gastroenterologists. With the support of this team and my incredible family, I've managed to continue working, albeit on a part-time basis.

The Income Generated by the NHS services reviewed in 2013/ 14 represents 100% per cent of the total income generated from the provision of NHS services by the Sandwell and West Birmingham Hospitals NHS Trust for 2013/14.

Participation in Clinical Audits

During 2013-14, our Trust has participated in 31 national clinical audits and 3 national confidential enquiries covering NHS services which the Trust provides. We reviewed all the data available to them on the quality of care in all of these services.

During that period, we participated in 100% of national clinical audits and 100 % national confidential enquiries of which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Sandwell and West Birmingham NHS Trust participated in and for which data collection was completed during 2013-14, are listed in attached Appendix 3 along with key findings and learning areas.

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We reviewed, along with the providers, 18 local clinical audit reports in 2013-14, these are listed in Appendix 4, with key learning areas and findings.

Participation in Clinical Research

During 2013/14, we recruited in excess of 2000 patients, all of which are receiving NHS service care from our Trust, to participate in research approved by a research ethics committee for National Institute for Health Research (NIHR) Portfolio studies. With a further 800 for non-NIHR Portfolio studies.

Participation in clinical research demonstrates our ongoing commitment to improving the quality of care offered and to making a contribution to wider health improvement. Engagement with clinical research also demonstrates the Trust's commitment to testing and offering the latest treatments and techniques. It further ensures that clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

We were involved in conducting over 250 clinical research studies during the 2013-14 period, of which around 200 were UK Clinical Research Network (UKCRN) portfolio studies. Research is undertaken across a wide range of disciplines including Cancer (breast, lung, colorectal, haematology, gynae-oncology, urology), Rheumatology, Ophthalmology, Stroke, Neurology, Cardiovascular, Diabetes, Gastroenterology, Surgery, Dermatology and Women and Children's Health. We use national systems to manage the studies in proportion to risk and implements the NIHR Research Support Service standard operating procedures.

2.8 What others say about us

Health Education West Midlands Visits

The Health Education West Midlands (HEWM) Visits are vitally important in the ongoing development of good training practice we provide at Sandwell and West Birmingham Hospitals. Training undergraduate and post graduate staff plays a big part in developing staff to be kind and compassionate as well as efficient and effective within their role.

HEWM visited the trust 7 times within the last year, looking into areas such as the Medical training provided Plastic Surgery, Emergency Medicine and Obstetrics and Gynecology. Below is a selection of the positive feedback we received during these visits.

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The Clinical Tutor involvement in exploring issues/identifying possible areas of concern from the GMC NTS and JEST is commended.

Following previous concerns raised with regard to the collaborative working with nursing staff, the overall opinion of Trainees is that once trust is gained by the nursing staff, the interaction and team work is good.

Trainees commend the support provided by the middle grade, with the exception of locum cover. In particular, one consultant was clearly identified by Trainees as an enthusiastic and passionate about education and training within the Emergency Medicine Department.

Care Quality Commission (CQC) Registration

The Care Quality Commission is an independent regulator of all health & social care services in England. The Commission checks all hospitals in England to ensure they are meeting national standards and they share their findings with the public.

What are the national standards?

- The national standards cover all aspects of care including:
- Treating people with dignity and respect
- Making sure food and drink meets people's needs
- Making sure that the environment is clean and safe
- Managing and staffing services

All health and social care services in England have to be registered with the Care Quality Commission (CQC). Our hospital is registered with no conditions, meaning we are safe to practice and our patients are in good care.

The CQC regularly inspect Trusts without or with very little warning to ensure the standards listed above are met. The table below details our 2013 inspection and the findings.

Date	Site	Inspection Details	Rate	Outcome
June 2013	Sandwell General Hospital	Respecting and involving people who use services	✓	Met this standard
		Consent to care and treatment	✓	Met this standard
		Care and welfare of people who use services	✓	Met this standard
		Assessing and monitoring the quality of service provision	✓	Met this standard

June 2013	City Hospital	Respecting and involving people who use services	✓	Met this standard
		Consent to care and treatment	✓	Met this standard
		Care and welfare of people who use services	✓	Met this standard
		Assessing and monitoring the quality of service provision	✓	Met this standard

Feedback

The overwhelming majority of people that we spoke with during the inspection, told us that they were happy with the quality of service they received. One person said "I don't think that anything could be done better."

During this inspection we found that there had been significant improvements in this area. Whilst we acknowledge that there were on-going areas for improvements, such as staffing and completing the reorganisation of the complaints process, the Trust had plans in place to support this. We therefore found that there was an effective system to regularly assess and monitor the quality of service that people received.

All the people who were in-patients and their relatives that we spoke with told us that their medical and nursing needs were being met. One person told us, "They really look after you, more than fit for purpose." On all the wards that we visited, we saw that staff were generally caring and committed to their work. We found that people experienced care, treatment and support that met their needs and protected their rights.

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West Midlands Quality Review Service

West Midlands Quality Review Service (WMQRS) was set up as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

WMQRS audited in February 2013, the purpose of the visit was to review compliance with West Midlands Quality Review Service (WMQRS) Quality Standards for:

- Care of People with Long-term Conditions, Version 1.1, August 2012
- Care of Children and Young People with Diabetes, Version 1.2, June 2012
-

Service	Number of Applicable QS	Number of QS Met	% met
Care of Children and Young People with Diabetes			
Primary Care	3	3	100
Specialist Care of Children & Young People with Diabetes	29	25	86
Trust-Wide: Sandwell & West Birmingham NHS Trust	4	4	100
Commissioning	7	7	100
Health Economy	**43**	**39**	**91**
Care of Adults with Long-Term Conditions			
Primary Care	8	1	13
Community Long-term Conditions Services	52	35	67
Specialist Care of Adults with Diabetes	59	44	75
Specialist Care of People with COPD	56	25	45
Specialist Care of People with Heart Failure	57	20	35
Specialist Care of People with Chronic Neurological Conditions	58	24	41
Trust-Wide: Sandwell & West Birmingham NHS Trust	7	3	43
Commissioning	12	4	33
Health Economy	**309**	**156**	**50**

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Feedback

This review found many individual teams who were caring for their patients and very committed to providing good services. Reviewers were impressed that the 'SystmOne' IT system was used by community staff and 60% of GP practices. This meant that information about patients could be easily shared between community staff and GPs.

Good care for children and young people with diabetes was provided by a committed team who had worked hard with commissioners to develop a quality service. The requirements of Best Practice Tariff were already being achieved due to robust service organisation. There was also good collection of data to support management of the service. The service had strong leadership and a forward-looking approach was apparent throughout the service, including in education programmes. The service was appreciated and highly praised by the parents and patients who met the visiting team.

Risk Review of Theatres

Sandwell and West Birmingham Hospitals NHS Trust Board commissioned an independent review of risks in the Trust's theatres. This was in response to a number of Never Events within the theatre environment in City, Sandwell and Birmingham Midland Eye Centre (BMEC) hospitals, between June 2013 and January 2014. The focus of the visit was to review the processes and safety culture within the operating theatres, to identify areas of good practice, and also to highlight areas for improvement. The project scope was to:

- Review the Trust's corporate governance and risk systems specifically in relation to theatres
- Identify the level of safety culture and perceived risk that exists in the Trust's theatres based on corporate risk appetite, gaps in resources and weaknesses in process

✓ **Key Strengths**	✗ **Areas for improvement**
• Loyal workforce • Staff able and willing to raise concerns • Incident reporting culture embedded • Patient safety high on the agenda • Friendly, welcoming staff culture • Learning environment • Patients satisfied by level of care	• Informality leading to relaxed approaches to some safety processes • Some disengagement of medical staff in safety checks • Working / shift patterns for theatre staff which are compromising safety • Need to integrate BMEC into the organisation as a whole • Tighter control of document development • Cross site learning from near miss and actual events

Healthcare Associated Infection review by the Trust Development Agency

The NHS Trust Development Authority was set up to provide support, oversight and governance for all NHS Trusts on their journey to delivering what patients deserve.

The review conducted during February 2014 explored the infection prevention and control arrangements against the following ten criteria.

1.	Systems to manage and monitor HCAI	✓
2.	Clean and appropriate environment.	✓
3.	Information to service users and visitors.	✓
4.	Suitable accurate information on infections.	✓
5.	Prompt identification/appropriate treatment and care of patients with infection	✓
6.	Staff engagement in the process of preventing infection.	✓

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7.	Secure adequate isolation facilities.	✓
8.	Secure adequate access to laboratory support.	✓
9.	Have appropriate policies and assurance	✓
10.	Assurance (as far as possible) those healthcare workers are free from and protected from infection and are suitably educated.	✓

The report was overall very positive against each criteria with a small number of operational matters many of these were able to be corrected with immediate impact. There were no organisational risks identified that would pose a threat to the safety of care for patients or to the safety of the environment for staff.

2.9 Limited Assurance Report

The External Auditors are reviewing the Quality Account in May 2014 and will provide assurance following this.

2.10 Data Quality and Information Governance

We need to know that we are counting, recording and storing information about people's care very carefully. We have commissioned an external review of all our data reporting for key national indicators to take place to assure the organisation of the appropriateness of our national information reporting. We do not have concerns about inappropriate disclosure of data.

NHS Number and General Medical Practice Code Validity

Below is the National and Trust performance on validity of these data items as published through the Health & Social Care Information Centre (HSCIC) through Secondary User Service Data Quality Dashboard – Provider Based using 2013/14 financial month 10 data, which is the latest we have.

It shows we remain above the national benchmarks for all indicators in A&E apart from NHS number which is 95.2% against a national picture of 95.7%. We remain above all indicators for Outpatients except Patient Pathway Identifier (which is optional). We remain above all indicators for inpatients except for ethnic origin 95.0% nationally 97.9%, commissioner at 96.7%,nationally at 99.0%, patient pathway identifier (optional) and we are slightly below NHS number coverage at 98.9% which is national 99.1%, however we will be resubmitting our data with another NHS Number trace before year end.

NHS Number compliance

Data Set	Nationally	SWBH
Inpatients	99.1%	98.9%
Outpatients	99.3%	99.6%
A&E	95.7%	95.2%

General Medical Practice Code

Data Set	Nationally	SWBH
Inpatients	99.9%	100.0%
Outpatients	99.9%	100.0%
A&E	99.1%	100.0%

Clinical Coding Error Rate

The latest final Payment by Results external clinical coding audit shows the trust has a 1.2% error rate of patient spells that where audited that affected payment, the previous year was 2.0%.

The overall error rate is 5.9% for clinical coding in general with 2.0% for primary diagnosis coding and 13.3% for primary procedure coding.

Information Governance Toolkit (IGT) attainment levels

The Trust is compliant across the Information Governance Toolkit requirements for 2013/14.
A "Satisfactory" (GREEN) level, according to the HSCIC IG Toolkit grading scheme has been reached and a minimum Level 2 achieved for all requirements.
Over the coming year the Trust will build upon its current performance and further strengthen its position aiming towards Level 3 compliance.

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Part 3: Review of Quality Performance 2013/14

3.1 Peer Group comparisons

We strongly believe in comparisons to Trusts of similar size and type as ours to ensure we perform to our best ability, along with striving to perform alongside the best performing Trusts. This is used as a benchmark throughout our performance targets.

Identifying our peer group was completed by the Performance team who identified a mix of Foundation Trusts, non-Foundation Trusts, Local and Inner City Trusts with a geographical spread in which have similar levels of activity, and which access to data to Key Performance Indicators KPIs could be identified. These are:

- Bradford Teaching NHS Foundation Trust (BTH)
- Kings College Hospital NHS Foundation Trust (KCH)
- Royal Liverpool & Broadgreen University NHS Foundation Trust (RLBUH)
- The Royal Wolverhampton NHS Trust (RWH)
- University Hospital Bristol NHS Foundation Trust (UH Bristol)
- Worcestershire Acute Hospital NHS Foundation Trust (Worcs Acute)
- Northumbria Healthcare NHS Foundation Trust

Throughout part 3 of this document we have compared ourselves with our peer group in as many areas as possible. These tables show our 6 peers and the top achieving in which we benchmark.

3.2 Patient Safety & Incident Reporting

Safety culture or climate remains essential for the delivery of high quality care. The Trust continues to submit its incident data to the National Reporting & Learning System (NRLS) which provides comparative data with like sized Trusts. The comparative data shows that as at the September 2013 report we remain in the highest 25% of Trusts with a reporting rate of 6.7 per 100 admissions.

To further promote patient safety, a Patient Safety Summit was held in February 2014. The focus of the summit was to launch the use of MaPSaF, (The Manchester Patient Safety Framework). Those who attended used the tool to define where they thought both the organisation and their team were on the safety maturity matrix. The Trust Board underwent a similar exercise in March 2014. Our Clinical Teams have been asked to undertake “culture checks” within their areas of responsibility.

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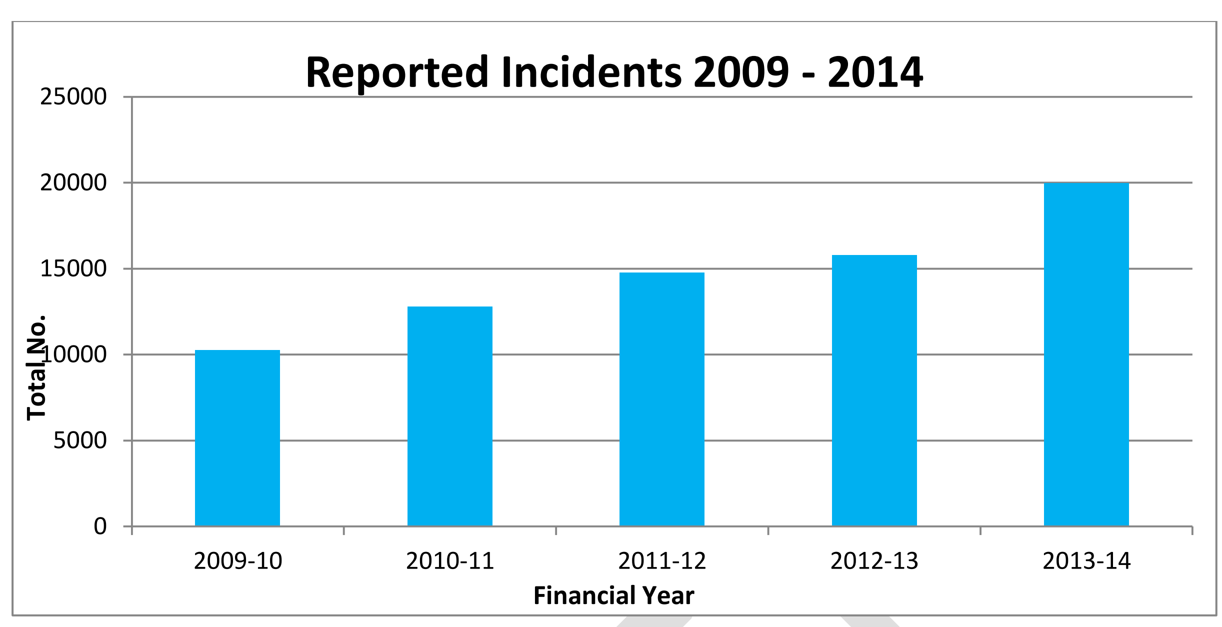

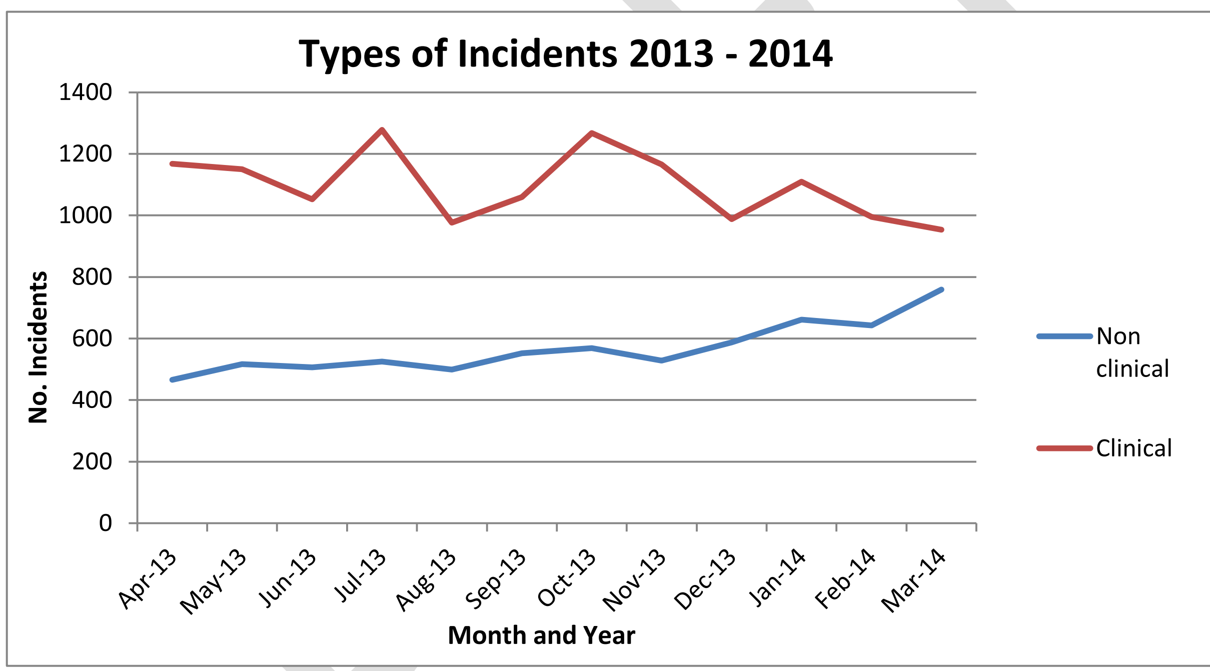

Incidents are generally categorised into clinical (patient safety) and non clinical and then further categorised depenant upon their cuasative factor.

The chart above shows the data for the main types of incidents throughout the year, month on month.
Serious incidents continue to be reported to the CCG and investigations for these are facilitated by the corporate Risk team. Those incidents designated as ‘amber’ are investigated at clinical group or corporate directorate level.

The number of serious incidents reported in 2013/14 is shown in the following table. This does not include pressure sores, fractures or serious injuries resulting from falls, ward closures, some infection control issues or health and safety incidents.

Month 2013/14	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
No. serious incidents reported	9	3	4	6	4	3	3	3	7	3	1	2

Never Events

Unfortunately last year we reported 5 never events, including one never event that occurred in the year before but was reported late. A never event is a serious untoward incident that has either caused or has the potential to cause serious harm that should never happen if the proper procedures are carried out to prevent them from happening. There is a list published by NHS England of 26 possible never events which include incidents such as 'Wrong Site Surgery', 'Retained Instruments or Swabs' and 'Wrong Implant'. The following table gives an overview of the never events that we reported with the key actions and learning points from each:

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Incident	What Happened	Where it happened	What we learned
Wrong Site Surgery December 2012 (reported July 2013)	A patient received an operation on their wrist instead of their elbow. This error was only detected when the patient returned for their outpatient follow up appointment	This incident occurred in the Plastic surgery service at Sandwell Hospital	The process for obtaining consent from patients should start in clinic at the time of decision to operate. In this case consent was obtained on the day of surgery and a failure to check the notes resulted in the wrong operation being done.
Wrong Implant June 2013	A patient having an intraocular lens implant for the treatment of cataract received the wrong strength lens	Operating theatres in the Birmingham Midland Eye Centre	Strengthening of the final step of the implant checking procedure. A change and reinforcement of the theatre visitor policy
Wrong Implant November 2013	During a total hip replacement	Orthopaedic theatres Sandwell	A rationalisation and reorganisation of implants

	operation the wrong size femoral head implant was selected for the acetabular cup size that had been implanted	Hospital	available in orthopaedic theatres. Reinforcement of the responsibility of the consultant in charge of the operation. A written implant selection procedure.
Wrong Site Surgery November 2013	A patient received the wrong laser procedure to their eye due to an error in identifying the patient	Outpatients department Birmingham Midland Eye Centre	A Trust wide learning alert on positive identification of patients in all settings. A review of never event risks in outpatient procedure areas.
Wrong Implant January 2014	A patient received the wrong strength intra-ocular lens due to a same name error resulting in the wrong electronic record being accessed	Theatres Birmingham Midland Eye centre	Operating in BMEC was suspended for three days whilst an investigation was undertaken. Reinforcement of the importance of team brief for catching unforeseen changes to the operating list. Locking down of operating lists 24 hours before. Video reflexivity exercise to reinforce safety behaviours. Identification of risks of partial EPR implementation.

Following this final never event we launched a major safety review of operating theatres across the Trust. We invited in external reviewers from the NHSLA to examine in detail our safety procedures, policies and culture. The recommendations from this review have been turned into a comprehensive plan of action for this year. This includes:

- Strengthening of our WHO Checklist steering group to look at all potential never events and gain assurance on control measures to prevent them
- A program of safety culture assessment using the MaPSAF tool
- A review and update of policies and procedures in theatres
- Incorporation of never events assurance audit as a CQUIN

We will report back our progress in all these areas in next years Quality Account.

Clinical Negligence Scheme for Trusts

The Clinical Negligence Scheme for Trusts is the maternity risk management standards of the NHSLA (NHS Litigation Authority) who utilise data from clinical claims to set standards.

Following on from their successful Level 2 assessment in February 2013, the Maternity service was assessed at Level 3 in February 2014. They were successful in attaining Level 3. This shows that as well as having the systems and processes in place to protect patients from harm, they can show this across all aspects of their service and consistently throughout the year.

Complaints

The Trust remains committed to providing timely and proportionate responses to formal complaints which it receives about its services. Complaints provide us with information about how patients and their families have felt about their experience, giving us information which we can use to improve. Equally compliments let us know what people have found has been good.

The table below shows the top themes of complaints received over the last 4 years, which we use with other patient experience mechanisms to set our priorities.

Category Type	2010-11	2011-12	2012-13	2013-14
All Aspects Of Clinical Treatment	553	573	578	406
Attitude Of Staff	161	127	142	115
Appointment Delay/cancellation outpatient appointment	126	84	94	45
Appointments Delay/cancelled inpatient	26	28	33	16
Communication/Information To Patient	92	55	66	53
Admissions/discharges, Transfers	44	42	59	21
Transport Services	12	17	7	6
Totals	**1014**	**926**	**979**	**856**

Complaints Handling process

In November 2013 the system for complaint handling changed to a largely devolved model. Complaint co-ordinators now assist staff within our services to address the complaints themselves and make any necessary amendments to services directly.

We have also set ourselves a target of 30 working days to resolve complaints and early indications are that complainants are being responded to in a more timely manner. However, there is further work to do to ensure we can meet these requirements consistently.

As part of the renewed process for handling complaints, we are offering more meetings to try and resolve issues directly. These meetings are recorded so that no delays occur in transcribing and the complainant receives an accurate record of the conversation.

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Date	Average rate of reporting per 100 admissions	Best reporter/ 100 admissions	worst reporter/ 100 admissions	Number of incidents resulting in severe harm	Percentage of incidents resulting in severe harm	Number of incidents resulting in death	Percentage of incidents resulting in death
2011/12	6.29	9.82	2.34	86	1.15	14	0.2
2012/13	9.58	12.65	2.49	32	0.32	19	0.15
2013/14*	10.59	11.06	3.85	6	0.1	10	0.2

The Trust submits data to the National Reporting and Learning system which is nationally and publicly available. The latest data (April - September 2013) shows the Trust has improved its position in the rate of reporting resulting in it remaining within the top 25% of large acute Trusts. The data shows an improving position for incidents which result in severe harm but a fairly static picture for those which result in death. The table shows the Trusts position per 100 admissions as compared against the best and worst reporters and the previous financial years position on reporting of degree of harm.

3.3 Safeguarding Adults and Children

Children's safeguarding

13/14 was a particularly challenging year with recruitment of new team members, change in leadership , local Offsted reviews and the development of new models of working with our partner agencies. The latter part of 13/14 saw the development of Multi Agency Safeguarding Hubs (MASH) in the Sandwell side of our community- where key agencies (health, police, social services) meet together. The aim being that organisations work closely together to identify the level of potential risk to the child and put actions /support in place to reduce the risk and protect the child. Other areas of priority this year have been staff training-99% of all staff (7,500) have received Children's Safeguarding information leaflets , 68% of staff identified have received face to face training regarding recognising and referring concerns regarding potential child abuse and 84%of staff identified (community children's services, A&E nurses and doctors , Health Visitors etc) have received higher level training regarding children's safeguarding We have employed four more team members to meet the demands of growing pressures and this includes a nurse to support victims of domestic abuse. We have set key targets to increase the number of Health Visitors who receive supervision regarding their role in child protection cases and we aim to undertake some analysis of key themes and gain feedback from children and families involved in this process. This will influence how we shape our service in the future to protect children.

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Patient Scenario

Following assessment in baby clinic concerns were raised regarding a child's development and mom's ability to provide essential care. This concern was discussed with the Safeguarding Team who prompted a multi-disciplinary meeting (with social workers, doctor etc). This resulted in a plan of care being developed which directed ward staff to observe mom's interaction with the child. Reports from ward staff, Health Visitors, doctors and social workers resulted in the recommendation of transfer of main carer role to dad , who was supported by the social worker and discharge planner to make arrangements for discharge.

This illustrates how a concern is identified, referred on, investigated, resulting in a plan of care (multi professional) which supports the family and protects the child. It illustrates that training and policies support front line staff to protect children.

Adult's safeguarding

The Safeguarding Vulnerable Adults Team supports staff in the organisation to protection the most vulnerable and frail in our society. Some of this work consists of identifying when a vulnerable adult may be a risk and reducing that risk by putting nationally defined actions in place. We aim to increase harm free care from 13/14 94%(falls, pressure damage) . In 13/14 the team received 727 referrals where staff needed advice/support or where harm needed to be investigated. Investigations illustrate the need for continual staff training:
Staff are trained according to their role /grade. 99.% of our 7,500 staff received leaflets outlining forms of harm/abuse and who to contact for support . 65% of senior staff (nurses, doctors etc) received classroom training on actions to take to protect patients and investigate harm incidents.
We undertake audits to review how we support vulnerable patients who may not be able to make decisions unaided (mental capacity) and these illustrate more patients/families are being involved in some difficult /complex decisions. There is still work to do.
We have undertaken a major project to improve the environment for patients with dementia and their carers following a successful bid to the DOH – bathrooms have been up-graded, rooms decorated, furniture purchased, conservatory built, lighting improved etc. we have invested money in University training for staff and employed activity co-ordinators to provide patients with dementia therapeutic activity. Next year we will be evaluating whether these improvements have had a positive effect on the experience of patients with dementia (length of stay , carers survey).

Safeguarding Vulnerable Adults Training continues as planned throughout 2013/14. The Trust continues to raise awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards and all staff received leaflets attached to their wage slip in 2013. The trust continues to work with the Police on training for staff regarding vulnerable people who may be converted to Terrorism.

The Learning Disability Liaison Nurse continues to work across the Trust with patients from Sandwell, this has seen a reduction in complaints and improved care for patients especially at the end of life. The Trust has a comprehensive plan to improve the care of patients with dementia which has seen a number of changes to ward environments. The Trust has

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employed three Activity Coordinators to work with patients with dementia ensuring they remain active and involved in their care during their hospital stay.

Patient Scenario

Lady was admitted who had a moderate Learning Disability who had a left sided weakness, and was diagnosed with a stroke. The left sided weakness improved but her swallow remained affected and she had a feeding tube fitted. The lady was diagnosed with Pneumonia whilst a patient. Multi-disciplinary team discussions were held around end of life care including support from her psychiatrist and the home manager and an advocate service due to the lady having no friends or family to help doctors make decisions. Decisions included if the patient should be for resuscitation and if a chest drain to drain fluid from her lungs should be considered, it was agreed that if this procedure would be considered for a patients without a Learning Disability then the procedure should be considered for this lady. This procedure was then completed and with a course of antibiotics her condition improved and she was discharged back to the home that she had lived in for a number of years. Community services were put in place to support her discharge.

3.4 Nursing Care Standards

Safety Thermometer

This tool which was introduced by the Department of Health enhances the understanding of harm free care experience by our patients in 4 specific areas:

1. Pressure Ulcers
2. Falls
3. Catheter-associated Urinary Tract Infections
4. VTE

We intended to continue to improve the safety and enhance patient experience through specific attention to the reduction of harm events and through efforts to measurably improve care delivered.

The Safety Thermometer audit is completed trust wide including Community services on a pre-prescribed day, once a month. The data is then submitted to the NHS Information Centre which is then published nationally.

The monthly whole Trust audit of patients for three harm free events has been accepted very positively with good engagement of nursing staff.

The Trust harm-free percentage for 2013-/2014 dipped mid-year, but it has improved to 94% which is just below the target.

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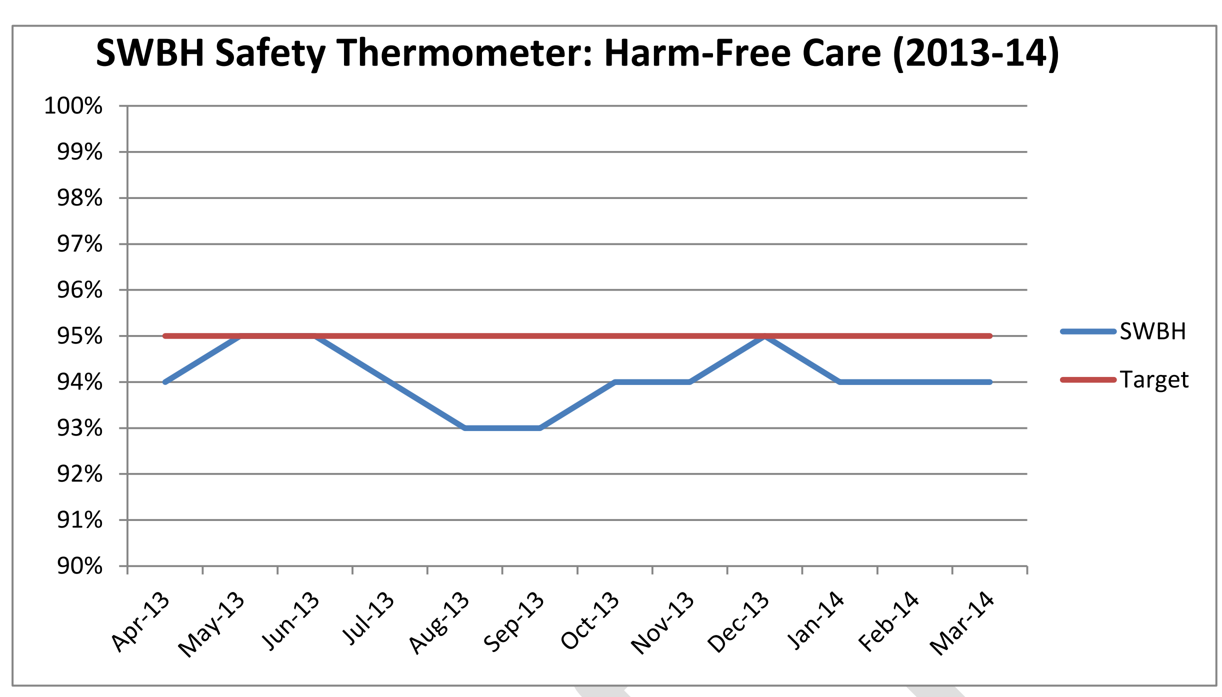
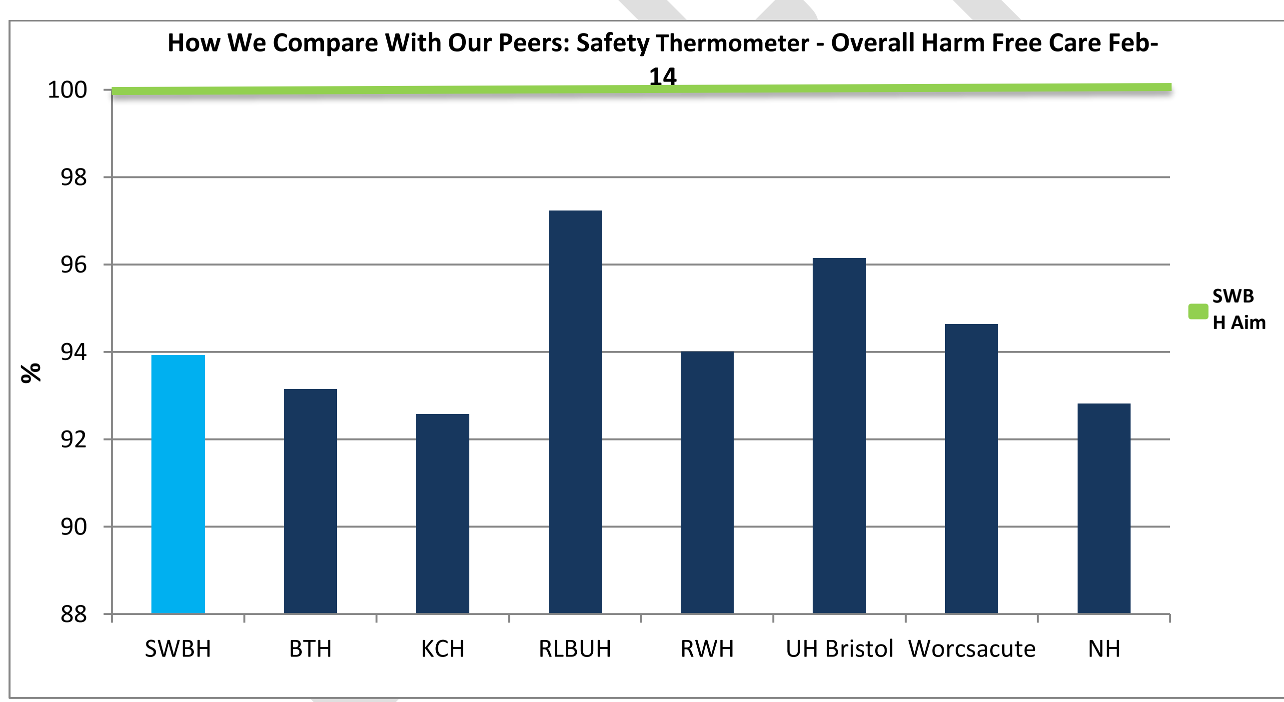


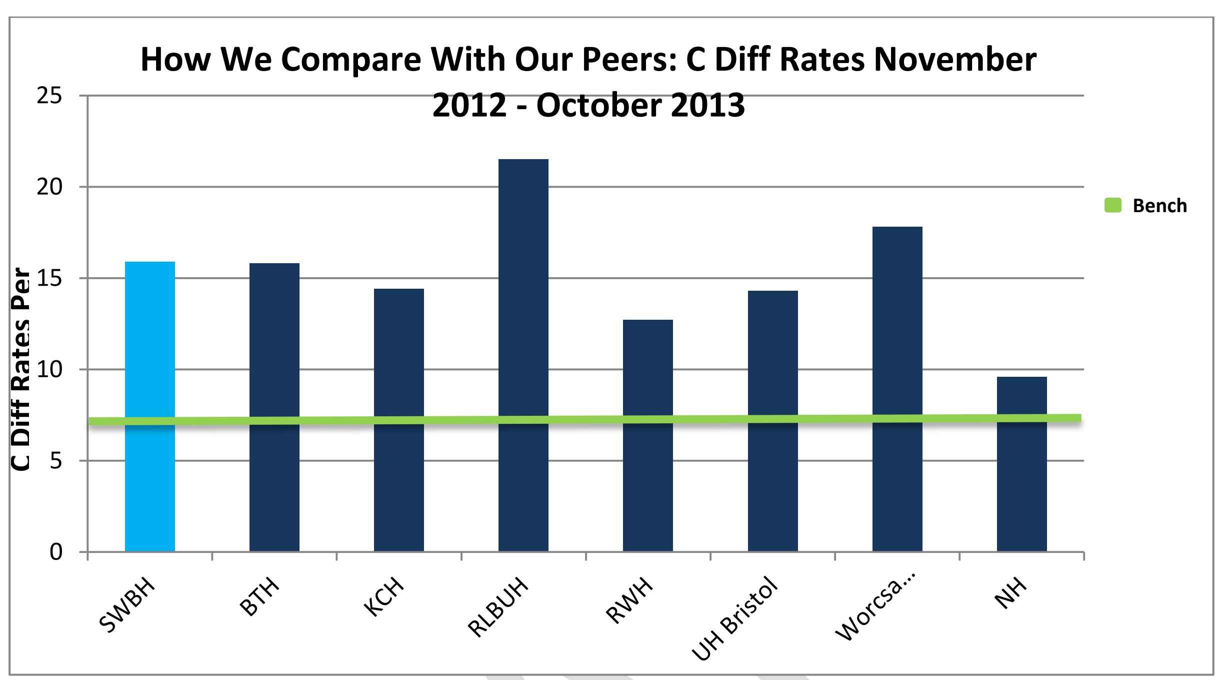


Infection Prevention and Control

C. Difficile (C. Diff) Incidences

In 2013/14 we have been very successful in keeping well below the number of occurrences agreed by the department of health, with only 39 occurrences of C. Diff. against a trajectory of 46 during the past year.

Actions to achieve this good performance included hand hygiene audits, a reduction in the use of antibiotics and maintaining a high level of environmental cleanliness.



Element	Performance and Action
C Diff	39 cases for the year against a target of no more than 46 cases.
MRSA blood stream infections	2 cases for the year against a zero tolerance target.
MRSA Screening	Elective - 78% against target of 80%. Non Elective - 78% against target of 80%.
Antibiotic Stewardship Programme	Improved access to antibiotics guidelines ('Microguide' application accessible on mobile phone devices). Achievements this year include Allergy status above 97% and prescribing compliance above 90%. Redesign of hospital drug-charts in progress to improve documentation targets.

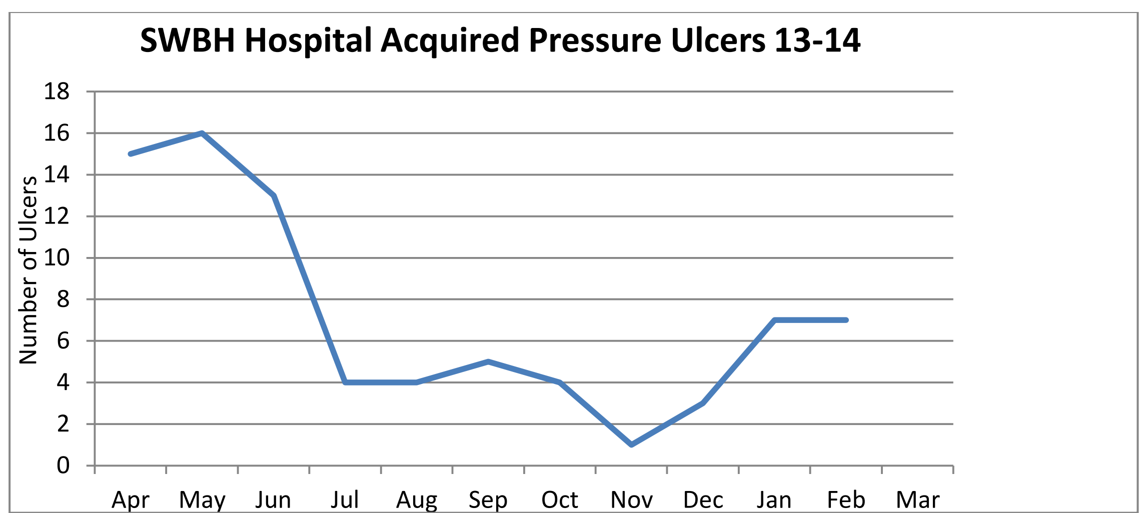
Pressure damage

Reducing avoidable pressure ulcers

Following the implementation of a focussed pressure ulcer reduction campaign, the incidence of avoidable hospital acquired pressure ulcer has been reduced by 54% during the last twelve months. Many of our wards have achieved sustained elimination of pressure ulcers with the highest celebrating 600 days pressure ulcer free.

All severe pressure damage is reviewed to identify the cause and implement local actions reflecting the lessons learnt.

Following the success of in reducing pressure ulcer incidences within the Hospital setting, focus of the pressure ulcer reduction campaign will be placed on reducing incidences within Sandwell Community and patients under the care of our District Nursing teams.



Patient Falls

We continued to reduce the overall number of falls in 12/13 by over 10% , however there has been an increase in the number of falls resulting in harm to our patients (for example a hip fracture /head injury) from 17 in 12/13 to 30 in 13/14 . We investigate and review each one of these serious incidents and determine whether different actions could have reduced the risk of the fall happening. Out of the 27 reviewed to date it was determined that in 13 incidents the organisation believes we could have reduced the risk of the patient falling. For example , we have determined that on some occasions the patient required a higher level of supervision by nursing staff or that greater accuracy of transferring information from one department to another was required. We continue to invest in equipment, training – all staff receive prevention of falls on induction and annual mandatory training. A new initiative recommended nationally Fallsafe will be implemented this year to co-ordinate the best practice in reducing the risk of falls- this includes a detailed review of medication and the use of specific care bundles (plans of care).

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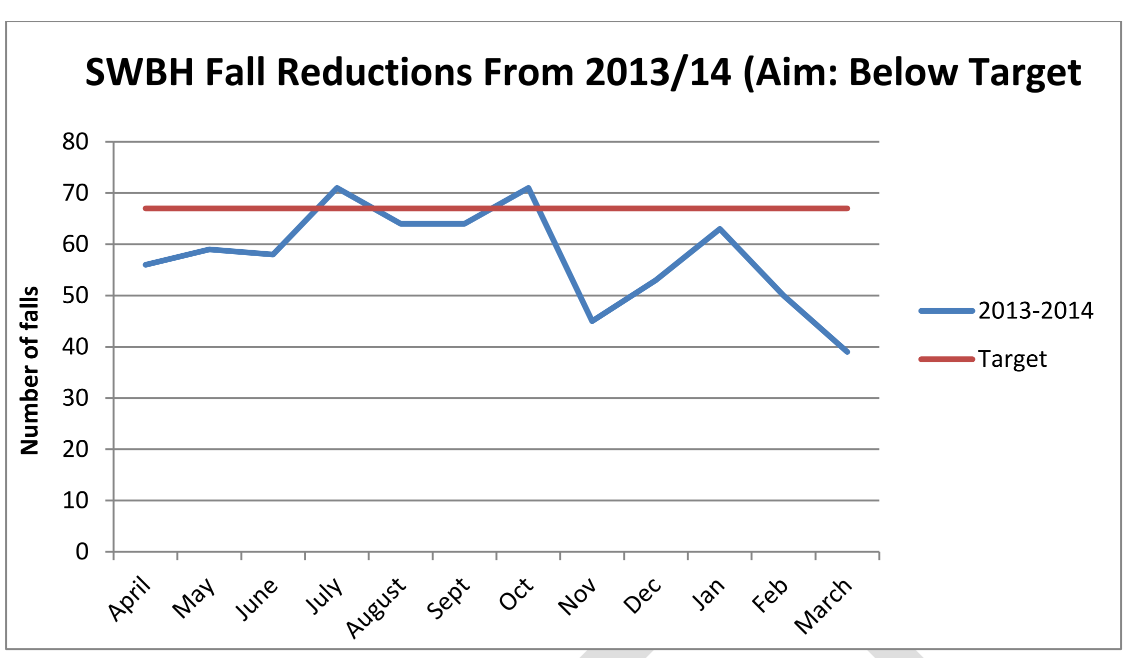

Dementia

13/14 has seen many developments to improve the care of patients with dementia and their relatives. The organisation was successful in bidding for funding from the Department of Health to ‘enhance the healing environment’ and this had led to structural and visual improvements in wards to support the care of patients with dementia. We screen patients to determine risk of dementia which may lead the patient to undergo a further assessment. We have supported the training of staff at university to increase knowledge of the signs and symptoms, treatment and care of patients with dementia and the needs of their carers. We have recently employed three staff to provide activities and therapy to this group of patients. The above strategies aim to improve patient and carer experience and reduce harm to patients.

Palliative and End of Life Care

We said we would increase, by a further 10%, the number of patients known to the specialist palliative care team achieving their preferred place of care/death in both the acute hospitals and the community. This means that patients and their families have been involved in discussions about their condition and have talked about what is important to them including where they want to be cared for and where they want to die.

The 63% target has been exceeded every month since April 2013 with an overall achievement of 74%.

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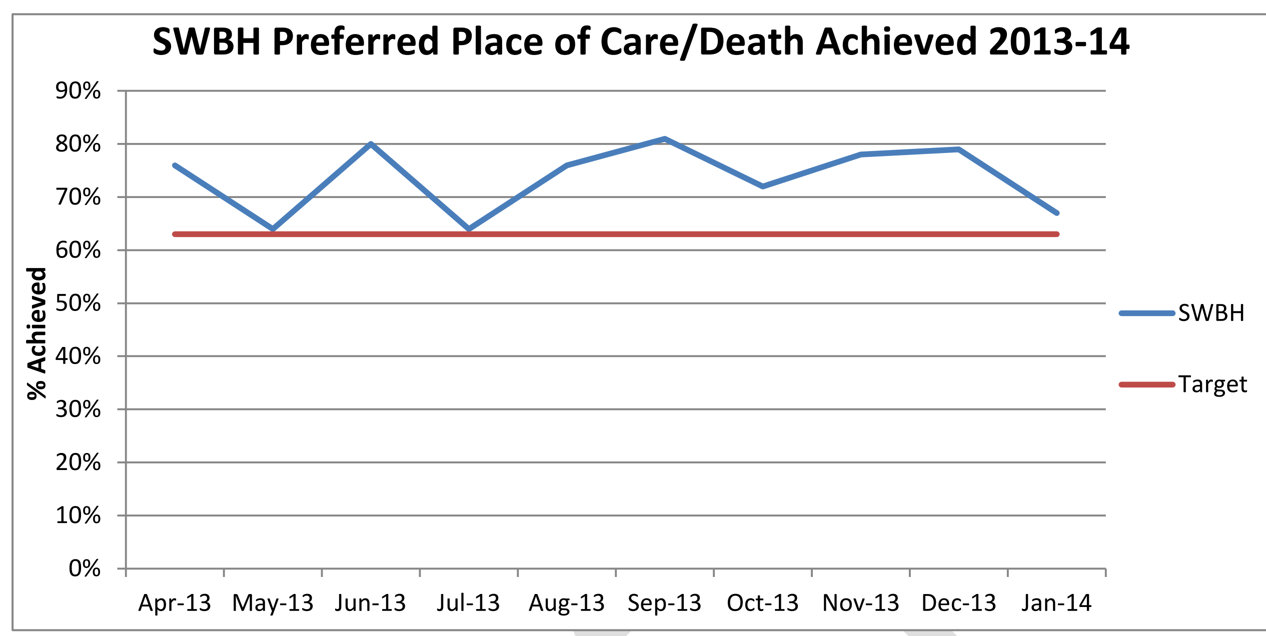

The specialist palliative care service has been developing over the past few years and is now delivering a seven day visiting service and advice out of hours in both the acute hospitals and community. This service focuses on ensuring that people who have an advanced life limiting illness are supported to improve or maintain their quality of life.

Just a note to say thank you for all you did for my dad through such a difficult, painful period at the end of his life. You got to know he was a proud, independent man but he trusted you completely and took real comfort and reassurance from your kind, practical care. Personally I would also like to say just how much your professionalism, combined with genuine compassion helped me care for Dad and grant his final wish to be at home.

I would like to take this opportunity to thank you for the support and compassion which your team afforded my late husband and I. Throughout the last days of his life the care was exemplary. I thank you for your openness when conveying difficult information regarding my husband's health. Your professionalism and respect will never be forgotten

3.5 Improving Patient Experience

Involving our patients, relatives, carers and community in improving patient experience is central to our success as an organisation. It is at the heart of the NHS Constitution (DH, 2009) and increasingly is also a key indicator of a performing NHS.

The Trust seeks patient views in a variety of ways including the national patient inpatient and outpatient surveys, and a trust-generated internal inpatient survey. The internal survey generates around 1000 replies every month which is in excess of 10% of inpatient admissions. This survey is given out to patients when they are discharged and is available in easy read format and other languages. What we find out from these surveys really does help us to shape the services we deliver.

Everyone can contribute, everyone matters and it is everyone's business to improve help us care for our patients, carers and relatives better. More and more there is evidence that a patients having a positive experience results in patient feeling better sooner feeling like they have had a good quality service. Patients often remember the little things – a smile, a kind tone of voice, kind words and someone there to hold a hand. This is what matters to us all.

Patient experience will improve if Trust staff are motivated to do everything they can to make patients feel cared for. Paying attention to equality and diversity is also an essential requirement to be able to achieve good patient experience and good outcomes.

The Trust is fully committed to developing and supporting patients, carers and relatives to play an active role in all aspects of the planning, delivery and evaluation of its acute and community health care services.

In early 2013 the Trust produced its first Patient Experience Strategy in which the key challenge is that all staff constantly question "How does this practice, information or change affect patients, carers and relatives? Does it improve the experience?" The only way to know the answer is to ask and to listen.

2013/14 was the first full year of the Patient experience strategy in use, all staff have welcomed the strategy, allowing all patients to fully benefit from improved care and services as a result.

Patient Reported Outcome Measures (PROMs)

PROMs assess the quality of care delivered to NHS patients from the patient perspective. Currently these cover four clinical procedures where the health gains following surgical treatment is measured using pre- and post-operative surveys. The Health & Social Care Information Centre publish PROMs national-level headline data every month with additional organisation-level data made available each quarter. Data is provisional until a final annual publication is released each year.

The tables below shows the percentage of patients reporting an improvement in their health status following the procedure and the average adjusted health gain achieved compared against the average for England.

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Percentage reporting improvement

	Health Status Questionnaire Percentage improving			
	Finalised data for April 11 – March 12 (Published October 13)		Provisional data for April 12- March 13 (Published February 14)	
	National	**SWBH**	**National**	**SWBH**
Hernia repairs	**51.0%**	**40.2%**	**50.2 %**	**50.0%**
Hip replacement	**87,5%**	**88.4%**	**89.7%**	**88.2%**
Knee replacement	**78.8%**	**71.8%**	**80.7%**	**72.7%**
Varicose vein surgery	**53.6%**	**61.0%**	**52.7%**	**43.8%**

Average adjusted heath gain

	Health Status Questionnaire Average adjusted health gain			
	Finalised data for April 11 – March 12 (Published October 13)		Provisional data for April 12- March 13 (Published February 14)	
	National	**SWBH**	**National**	**SWBH**
Hernia repairs	**0.087**	**0.047**	**0.085**	**0.088**
Hip replacement	**0.416**	**0.405**	**0.438**	**0.369**
Knee replacement	**0.302**	**0.247**	**0.319**	**0.271**
Varicose vein surgery	**0.095**	**0.100**	**0.093**	**0.053**

(amber)	SWBH below England average
(green)	SWBH above England average

The finalised data for 2011/12 and the provisional data for 2012/13 shows that there are areas where the reported outcome is below the average for England.

In response, the Trust has taken action the following action

	Action taken
Hernia repairs	**Work to ensure 80% questionnaires handed out. All patients seen and listed have been audited to ensure cases listed are symptomatic and have copies of letters. Consented appropriately. Risk and benefits explained. Introduction of Hernia clinic and listed, piloted and gradual roll-out from Feb 2014.**
Hip & Knee replacement	**Streamline questionnaire hand out process to ensure >80% uptake. A joint club in place and information leaflets given. Discussion with patients so they are fully aware of the risk and benefit as well as expected outcome. Audit of listing of Cases to ensure meets criteria consistently for replacement and meets the current CCG guidance. A contact point after discharge if there are any problems. A six month follow up and review of performance after surgery.**

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Varicose vein surgery	Most varicose veins are now done by radiofrequency ablation here. Questionnaire given on the day seen. Current wait times mean many of these are invalid and process has to be repeated. Current work is being undertaken to reduce wait time to ensure consistency. All patients have discussion regarding risk and benefits.

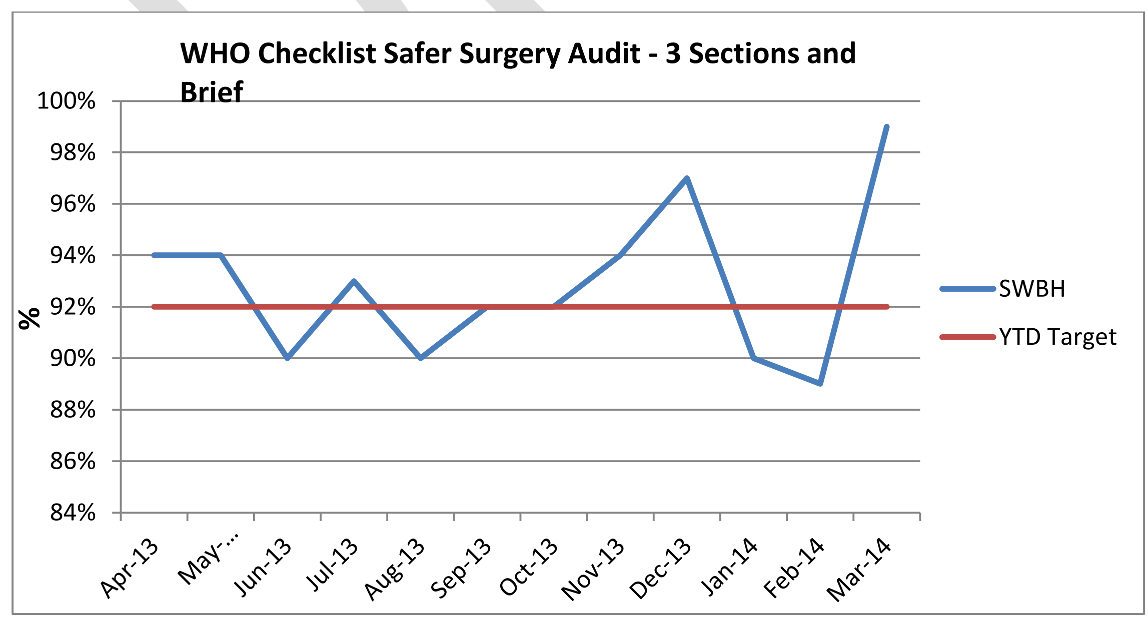
Alcohol Screening Programme

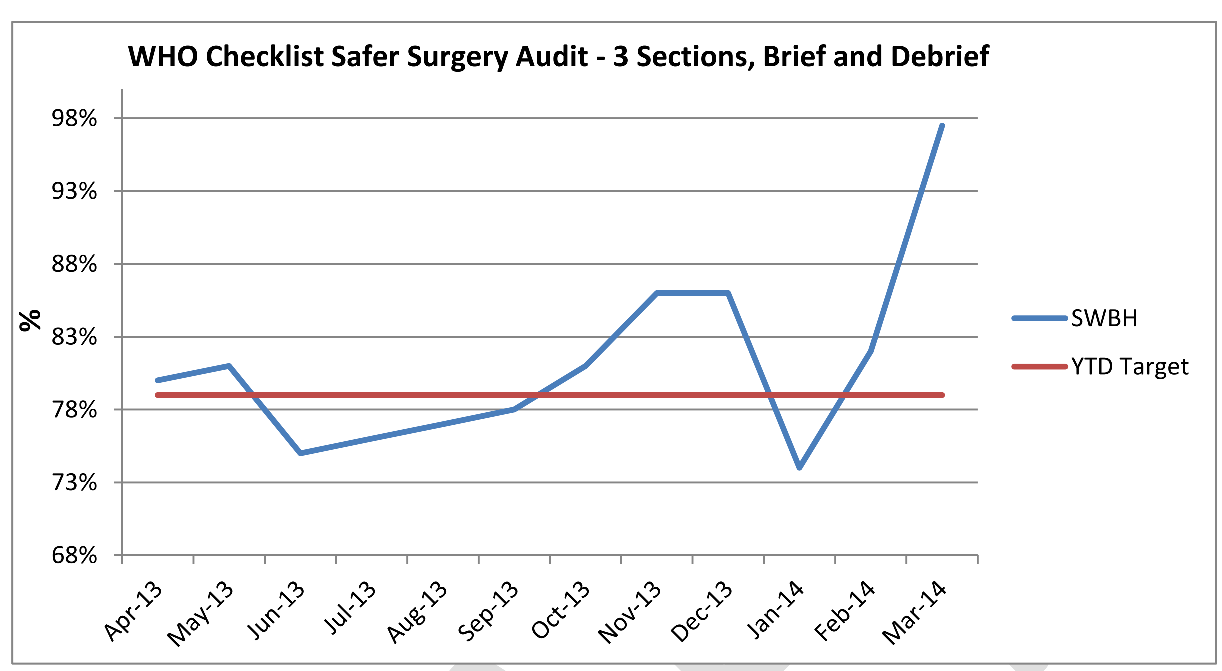
We agreed with the commissioners to carry out screening of patients to check if they are at risk of harm from alcohol. It is very important to assess alcohol risk to ensure that patients are treated appropriately and also to be able to advise them on health issues if appropriate. This is now one of our key objectives in our Public Health Strategy.

WHO Surgical Safety Checklist

During the year we have continued to have regular WHO checklist committee meetings to monitor compliance with the checklist. Monthly compliance of completion of all five components of the checklist in all areas is monitored.

There remains a high standard of completion in all areas, with debrief being marginally lower than other sections.
Intermittent notes based audit cross-check against this data to ensure recording accuracy.
We have focused on quality of completion ensuring it does not become a tick box exercise, and regular qualitative reviews by observers of the checklist process, giving instant feedback to teams is conducted at intervals.
We have approved several updated versions of the checklist for specific areas, following on from review of incidents or locally differing requirements.
In February we introduced a compulsory check on ORMIS (operating theatre computer system) to highlight the completion of three areas of the checklist. This will make the collection/entering of audit data less onerous for staff. However, during the changeover period there will be difficulty in data collection as the team brief/debrief components are recorded separately per list, leading to some short term data inaccuracy.





3.6 Staff Indicators

Staff Engagement

In September 2013 we introduced 'Your Voice'. This is an online staff survey which is sent out via NHS mail accounts to a third of our staff every month, so that every 3 months we get results back for the whole trust. The survey uses the same nine questions which are used in the national NHS Staff Survey to measure levels of staff engagement. This gives us a staff engagement score for each group, team and directorate in the trust. The overall response rate to date is 21%, which is good for an online survey. The survey also uses 5 free text questions:

What top 2 things could we introduce or improve to make you more positive about working at the Trust?
What are the 2 most significant things that you would like to pursue within your area of work to make your service even better for patients?
How do you feel about working for the Trust?
Do you know what the Your Voice results are for your area of work?
Are you aware of any changes that have happened as a result of Your Voice?

These questions enable local management teams to respond on a 'You said, we did' basis and for us to be able to monitor our progress. To date each area of the Trust has completed the survey twice and we have seen that where teams have responded positively to the issues raised by staff, their engagement score has improved considerably. Our pioneering approach to staff engagement 'Listening into Action' continues to be widely used and is now

being used to help address issues raised through the Your Voice survey. Our overall score for staff engagement, as determined by the NHS staff survey, improved in 2013 and is average when compared to acute Trust's nationally.

Key Staff Performance Indicators

A range of workforce KPIs are included in the Trust's Performance Management Framework which include specific targets against which all Groups/Directorates are performance managed.

Staff Turnover

Employee turnover rate has averaged 11% over the year 13/14. This level of turnover is slightly higher than is considered ideal but will in part to a result of our on-going workforce transformation programme and the age profile of our workforce. We are closely monitoring turnover at Group/Directorate and staff group level and focusing on improving our retention rates in specific areas. Our approach to retention includes improved leadership skills, employee engagement, personal/professional development to ensure we are creating an environment whereby our employees are motivated, engaged and empowered to maximize their potential.

Appraisal

We are committed to ensuring that all of our employees have received an annual appraisal. It is anticipated that our compliance rate will be close to 100% by the end of the 13/14 financial year. The plan moving forward will be to build on that platform and improve the quality of the appraisals undertaken. We take close note of the feedback from our national staff survey results which currently confirm that of those who were appraised 60% said it had helped them to improve how they did their job; 83% said it had helped them agree clear objectives for their work; and 66% said their appraisal left them feeling that their work was valued by their organisation.

Sickness Absence

Our sickness absence rate is currently above the Trust's target with the current year to date figure at 4.33%. Our approach to reducing sickness absence is integrated within our newly developed Public Health Strategy as set out below:

Current position:

- There is a high level of musculoskeletal and mental health issues among the long term sick in particular
- In 2013 the Trust's sickness absence rates are still over 4%
- There is significant sickness associated with Trust investigatory and disciplinary procedures

• There is no mental health training regularly available to managers. When undergoing an investigation

• Health and Wellbeing training will be mandatory for employees

Aim by 2017:

• We will have no higher than 3% sickness absence (2% long term and 1% short term)

• We will have a rate of work related illness that has fallen year on year

• will have mental health training within the Trust for managers

• We will have developed a range of short interventions to support particular groups of employees at difficult times – e.g. when undergoing an investigation

• Health and Wellbeing training will be mandatory for employees

Recruitment – Time to Fill Posts

The time it takes the Trust to replace vacant posts thereby ensuring we maintain a full establishment and reduce our reliance on temporary staffing is critical in supporting the organization to provide a high quality and effective service.

We now routinely report our 'time to fill', identifying the time it takes to fill a vacancy from the point an existing employee tenders their notice to the date of commencement of the new employee. Our aim is to achieve an average 'time to fill' of 14 weeks. Our current median 'time to fill' is 15.8 weeks. We currently have some Groups that are already achieving this, and are working closely with all our recruiting managers to implement improvements where necessary.

3.7 What others think of our Quality Account

We invited our commissioners, the overview and Scrutiny Committees in both Sandwell and Birmingham and Healthwatch groups in Birmingham to tell us what they thought of our Quality Account.

On behalf of the Cross City CCG, the black country CCG commented:

- Much of the data in the review sections is well presented; supporting the assertions and claims made in the introduction.
- It is interesting that the achievements section is not balanced by a review of shortfalls! This is supposed to be a Quality Account and not a 'management report' and it should present objective findings with a balanced commentary – amended by Trust following feedback;

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- The Introduction would be better if the achievements were set against targets and previous year information.
- Report is incomplete. A number of important sections are missing including the Chairman's Statement – this was reviewed when in progress, trust has completed report following feedback;
- Many important actions are identified but there is no confirmation that they have been completed or when they will be completed.
- Many Audit Actions are described as intents with general goals rather than objectives or targets.
- Overall, fair and balanced in content.
- Very good use of patient stories, and report statements from visits
- Good explanations of outcomes to CQUINs and priorities in specific to patients
- Would expect the quality account to have visual aids/pictures to make account easy reading- the trust has inserted visual aids following completion of the report.

Birmingham Overview and Scrutiny Committee sent the following message.

Message sent on behalf of Cllr Susan Barnett, Chair Birmingham Health and Social Care Overview & Scrutiny Committee

The Birmingham Health & Social Care Overview & Scrutiny Committee ("the HOSC") recognises that healthcare providers publishing Quality Accounts have a legal duty to send their Quality Accounts to the HOSC in the local authority where the provider has its registered office, giving the HOSC an opportunity to comment on the Quality Accounts before publication.

The members of the Birmingham HOSC wrote to the Secretary of State for Health in May 2013 and again in November 2013 raising a number of practical issues including the number of Quality Accounts and volume of information, timing of receipt, time constraints within committee meetings, the degree of knowledge and expertise required to make informed comments, the fact that the Quality Accounts are reviewed by both internal and external auditors and the Clinical Commissioning Groups, all of which impact on the ability and capacity of the HOSC to provide a statement on Quality Accounts.

On Wednesday 30th April 2014 there will be an opportunity for Healthcare Provider Trusts to update the HOSC members about their response to the Francis Report, many of which actions will impact on quality and may be reflected in aspects of the Quality Accounts.

However, in the interests of avoiding any potential conflicts of interest and of not fettering its discretion to scrutinise matters which may arise in the course of the year, the Birmingham HOSC will not be supplying an audit statement on the 2013/14 draft Quality Accounts. The HOSC is circulating this statement so as not to hold up publication of the accounts.

Healthwatch Group Birmingham
[Awaiting feedback]

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3.8 How to provide feedback on this Quality Account

As an organisation, we would like to know what you thought of our Quality Account. After all, this document is for the public and we would like to know what you think. As a result of reading this document, do you think you have a better understanding of how committed we are to providing high quality care.

You can e-mail the Trust Board Secretary on simon.grainger-lloyd@nhs.net

Or send us a letter to Mr Toby Lewis,
Chief Executive,
D29 Corporate Management Suite,
Sandwell & West Birmingham NHS Hospitals Trust,
City Hospital
Dudley Road
Birmingham
B18 7QH

We will value your feedback.

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Quality Account Appendix 2013/14

Appendix 1 . Annual Governance Statement 2013/14

Appendix 2. Participation in Clinical Audits

During 2013-14, Sandwell & West Birmingham NHS Hospitals Trust has participated in 30 national clinical audits and 3 national confidential enquiries covering NHS services which the Trust provides. (Required Statements) The SWBH has reviewed all the data available to them on the quality of care in all of these services.

During that period Sandwell and West Birmingham NHS Trust participated in 100% of national clinical audits and 100 % national confidential enquiries of which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Sandwell and West Birmingham NHS Trust participated in and for which data collection was completed during 2013-14, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audits	Participated Yes /No	Percentage of eligible cases submitted (Provisional)
Women's & Child Health		
Neonatal Intensive and Special Care (NNAP)	Yes	100%
Paediatric asthma (British Thoracic Society)	Yes	71%
Paediatric bronchiectasis	Yes	33%
Diabetes (National Paediatric Diabetes Audit)	Yes	100%
Epilepsy 12 Audit (Childhood Epilepsy)	Yes	100%
Moderate or severe asthma in children (Care provided in Emergency Department)	Yes	100%
Acute care		
Emergency use of oxygen (British Thoracic Society)	Yes	100%
Hip, knee and ankle replacements (National Joint Registry)	Yes	93%
Severe trauma (Trauma Audit & Research Network)	Yes	70%
Severe sepsis, septic shock (College of Emergency Medicine)	Yes	100%
Adult Critical Care (Case Mix Programme)	Yes	100%

National Audit of Seizure Management	Yes	100%
Paracetamol overdose (College of Emergency Medicine)	Yes	50%
National Emergency Laparotomy Audit (NELA)	Yes	Ongoing
Long term conditions		
Diabetes (National Diabetes Audit) Adult	Yes	100%
Inflammatory Bowel Disease (IBD)	Yes	100%
Rheumatoid and early inflammatory arthritis	Yes	Ongoing
Heart		
Acute Myocardial Infarction & other ACS (MINAP)	Yes	88%
Heart Failure (Heart Failure Audit)	Yes	50%
Cardiac Rhythm Management Audit	Yes	100%
Acute stroke (SSSNAP)	Yes	90%+
Cardiac arrest (National Cardiac Arrest Audit)	Yes	76%
Coronary angioplasty (NICOR Adult Cardiac interventions audit)	Yes	TBD
Cancer		
Lung cancer (National Lung Cancer Audit)	Yes	100%
Bowel Cancer (National Bowel Cancer Audit Programme)	Yes	100%
Head & neck cancer (DAHNO)	Yes	100%
Oesophago- gastric cancer (National O-G Cancer Audit)	Yes	100%
Blood and Transplant		
National Comparative Audit of Blood Transfusion (Audit of the use of Anti D)	Yes	100%
Older people		
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	99%
Other		
Elective Surgery (National PROMs Programme)	Yes	74%

National Confidential Enquiries (Clinical Outcome Review Programmes)		
Medical & surgical programme - National Confidential Enquiry into Patient Outcome & Death (NCEPOD) The Trust participated in the following study in 2012/13 - Subarachnoid haemorrhage - Low limb amputation - Tracheostomy study - Gastrointestinal Haemorrhage	Yes Yes Yes Yes	86% 100% 81% Ongoing
Maternal, infant and newborn clinical outcome review programme	Yes	100%
Child Health Clinical Outcome Review Programme	Yes	100%

Appendix 3. National Clinical Audits – Summary of Learning & Actions

The reports of 14 national clinical audits were reviewed by the provider in 2013-14 and Sandwell and West Birmingham NHS Trust intends to take the following actions to improve the quality of healthcare we provide:

Report	Findings, Our Learning, & Our Actions
Provisional Patient Reported Outcome Measures (PROMs) in England Audit description An audit of outcomes reported by patients undergoing hip replacement, knee replacement, varicose vein surgery and surgery for inguinal hernia repair	Key findings/learning The finalised data for April 2011 – March 2012 showed that the percentage of patients reporting an improvement in their health status was below the national average for England for patients undergoing knee replacement surgery and for patient following hernia repair. Action A number of steps have been taken to ensure that patients undergoing these procedures receive appropriate information and support. The actions have included the updating of information on risks and benefits and the implementation of guidelines for the listing of patients for surgery.
National Confidential Enquiry into Post-operative Outcomes and Death (NCEPOD) Report- 'Measuring the units' (Alcohol Related Liver Disease)	Key findings/learning The NCEPOD report highlighted that nationally that there were many missed opportunities in the care of patients who died with a diagnoses of alcohol related liver disease. There was a failure to screen adequately for harmful use of alcohol and even

Report	Findings, Our Learning, & Our Actions
Audit description This was an audit conducted by the National Confidential Enquiry into Post-operative Outcomes and Death (NCEPOD). It reviewed the process of care for patients who are treated for alcohol-related liver disease and the degree to which their mortality was amenable to health care intervention. Remediable factors were identified in the clinical and the organisational care of these patients.	when this was identified, patients were not referred for support. Action The recommendations contained in the report were reviewed. It was identified that additional resources were required to ensure that 7 day alcohol screening service was available, particularly within the Emergency Departments. It was reported that many of the recommendations would be addressed through the local implementation of the British Society of Gastroenterology's Care Bundle for Alcohol Related Liver Disease due to be published in 2014.Action was also required to further whether alcohol screening information could be captured electronically through the Emergency Department's patient management system' Patient. First'
National Confidential Enquiry into Post-operative Outcomes and Death (NCEPOD) Report- 'Managing the flow' (Subarachnoid Haemorrhage) Audit description This study examined the care of patients with aneurysmal subarachnoid haemorrhage (aSAH) from the time they present with symptoms until they are discharged from hospital following treatment. The report identified remediable factors in the clinical and the organisational care of these patients.	Key findings/learning Nationally the report highlighted that there are important lessons to be learnt in each step of the patient pathway starting with a need for a higher index of suspicion, in both primary and secondary care, that patients might have had an aSAH. Simple guidelines, if followed, should avoid delays in the diagnosis and management of acute severe headaches. Action Locally it was identified that there is a need to develop a protocol with the neurosurgery team at the local tertiary centre regarding criteria for acceptance for neurosurgical intervention. In addition, a re-audit of the completeness of neurological assessments was being undertaken to ensure that best practice is achieved.
National Neonatal Audit Programme – Annual Report 2012 Audit description The key aims of the audit are: • To assess whether babies requiring neonatal care received consistent care across England in relation to	Key findings/learning The audit showed that the reported compliance for the Trust was below the national average for some indicators. This included rates for the administration of antenatal steroids and the recording of the initial assessment and consultation with parents by a senior member of the neonatal team.

Report	Findings, Our Learning, & Our Actions
the audit questions; • To identify areas for improvement in neonatal units in relation to delivery and outcomes of care; • To provide a mechanism for ensuring consistent high quality care in neonatal services	Action It was considered that these findings were due in part to inadequate recording on the BADGER database system. Data from the BADGER system feeds into the national report and so actions to further improve data capture for were identified. For example to include a communication page in the admission pack. .
National Diabetes Inpatient Audit-2012 Report Audit description The National Diabetes Inpatient Audit (NaDIA) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) It is a snapshot audit of diabetes inpatient care in England and Wales. The aims of the audit include finding the answers to the following questions:- • Did diabetes management minimise the risk of avoidable complications? • Did harm result from the inpatient stay? • Was patient experience of the inpatient stay favourable?	Key findings/learning Nationally the NaDIA has shown that people with diabetes in hospital are older, sicker, have more complex disease, stay longer, require more complex treatments, suffer frequent medication errors and not infrequently come to harm. The NaDIA has documented that many hospitals remain under-resourced for diabetes care. Local audit findings highlighted some areas where improvements in performance against several quality markers were required. Action The need to improve education and training was identified as the uptake on current training opportunities was reported to be variable. It was also agreed to explore the potential for building the capability to run a cut-down version of the audit on a rolling basis.
The National Bowel Cancer Audit 2013 Report Audit description The audit is run in conjunction with the Association of Coloproctology of Great Britain and Ireland and is designed to assess whether patients with colorectal cancer receive the appropriate treatment for their cancer when it is first discovered.	Key findings/learning The report highlighted that there is variation in treatment and outcome around the country in aspects such as the proportion of patients presenting as an emergency, length of hospital stay, application of laparoscopic resection and major resection rates. Action To ensure that the data to be submitted to the audit is as accurate as possible, it is now reviewed by relevant teams and discussed prior to submission to ensure that it is as accurate and complete as possible. In addition, an audit of

Report	Findings, Our Learning, & Our Actions
	critical care support has been indicated to ensure the most effective patient pathway for emergency patients. Also, a review of dedicated emergency interventional radiology support, particularly for colonic stenting was also indicated.
National Confidential Enquiry into Suicide and Homicide for people with Mental illness - Annual Report 2013 Audit description The enquiry examines all incidences of suicide and homicide by people in contact with mental health services in the UK. They also examine all cases of sudden death in the psychiatric in- patent population.	Key findings/learning The report has been considered and although there are no specific recommendations requiring action, the Trust continues to ensure that its systems are robust in order to assess the level of suicide risk and to take appropriate action. This includes being alert to use of low lying ligature points, the risks associated with absconding of patients with mental health needs and the risks associated with drug or alcohol misuse. These aspects are addressed in local policies and by mental health liaison services.
National Oesophago Gastric cancer Audit Report 2013 Audit description The overall aim of the Audit is to measure the quality of care received by patients with oesophago-gastric (O-G) cancer in England and Wales. It will answer Audit questions related to:	Key findings/learning Overall the findings concluded that clinicians are providing a high quality of care for patients, and most encouragingly mortality for curative surgery continues to fall. Action Although the surgery is not performed at the Trust, it is nonetheless an important contributor to the pathway of care. The key recommendations contained in the report were reviewed and overall good compliance with relevant key recommendations was reported. The main area identified for improvement was in ensuring the attendance of an oncologist to the multidisciplinary team (MDT) meetings
National Heart Failure Audit – 6th Annual Report Audit description The National Heart Failure Audit was established in 2007 to monitor and improve the care and treatment of patients with an unscheduled admission to hospital in England and Wales with acute heart failure. The	Key findings/learning Nationally the report highlighted considerable variation in outcomes across hospitals and within hospitals. It highlighted that for the first time a modest but significant reduction in all-cause mortality, both during the index admission and over the subsequent period of follow up, is reported. More patients are being cared for within specialist cardiac care or cardiology wards.

Report	Findings, Our Learning, & Our Actions
audit collects data based on recommended clinical indicators with a view to driving up standards by encouraging the implementation of evidence based recommendations and by reporting on clinical practice and outcomes. .	<u>Action</u> Locally, it was reported that there was a need to increase the percentage of eligible cases being submitted to the audit as approximately 50% of eligible cases are currently being entered. The local findings based on submitted cases support that most patients are investigated and treated appropriately. As a result, a business case was being developed to ensure that the Heart Failure Service has the capacity to review more patients and to ensure that additional cases are entered into the national audit.
National Paediatric Diabetes 2011/12 Audit Report <u>Audit description</u> The National Paediatric Diabetes Audit (NPDA) collects data on the quality of care for children and young people with diabetes mellitus in England and Wales	<u>Key findings/learning</u> The national audit found that measurements of diabetes control (HbA1c) have improved, and the percentage of patients with HbA1c values in the target range has risen. Despite these achievements, fewer than one in five patients overall reach this level of diabetes control. The audit also found that the extent to which children and young people receive the care processes recommended by the National Institute for Health and Care Excellence (NICE) remained low. <u>Action</u> Overall, it was reported that the results locally compared favorably with national rates for England & Wales. The key recommendations contained in the report were reviewed and to further enhance the percentage of children achieving all NICE care processes a need to enhance dietetic input was identified. Action has been taken to address this.
National Head and Neck Cancer Report (8th Annual Report) <u>Audit description</u> The audit aims to establish whether care has been identified by a multidisciplinary team, delivered to agreed standards with equality of care and without undue delay. It also produces data on local recurrence rates and on mortality.	<u>Key findings/learning</u> The audit focused on reporting on variations by the multidisciplinary team (MDT) as the key hub of treatment integration. <u>Action</u> The key recommendations were reviewed and overall, good compliance was reported for those that were applicable to the Trust. An area identified for improved compliance concerned the requirement for a pathologist to attend multidisciplinary team (MDT) meetings and action

Report	Findings, Our Learning, & Our Actions
	to enhance input is being explored.
Adult Critical Care (Case Mix Programme) (ICNARC) – Summary Report October 2012 – September 2013 – Summary Report. <u>Audit description</u> The audit aims to promote local audit of critical care through the provision of comparative data. In addition, to promote the use of evidence in critical care practice and policy.	<u>Key findings/learning</u> The local summary report indicated an increase in early readmission rates within 48 hours of discharge. Out of hours discharges were found to be at national levels. Early unit deaths remained at or below national levels, but there was an increase in the period reviewed in the standard mortality ratios. This was contributed to by an increase in post unit discharge mortality rates. A review of relevant cases to be conducted to see if any lessons can be learnt. .
Child Health Reviews – UK – Coordinating Epilepsy Care <u>Audit description</u> The Clinical Outcome Review Programme: Child Health Reviews - UK (CHR-UK) is a UK-wide programme of work aiming to inform clinical practice and improve the healthcare provided to children and young people. This has included a themed case review of mortality and serious morbidity in children and young people with epilepsy at all stages of the care pathway.	<u>Key findings/learning</u> The review found an overall positive picture of good clinical care provided by clinical teams working in partnership with families. However, such care was not universal, and lessons can be learnt and improvements can be made. <u>Action</u> The key recommendations were reviewed and it was determined that a system of peer review of the clinical team caring for children and young people with epilepsies was required to be established, and a business case for a epilepsy specialist nurse made, in order to comply with best practice.
National Hip Fracture Database (NHFD) Annual Report 2013 <u>Audit description</u> The National Hip Fracture Database (NHFD) is a clinically led, web-based audit of hip fracture care and secondary prevention.	<u>Key findings/learning</u> The audit found that there was a progressive pattern of improvement across the four standards for which the NHFD has been the principal driver – orthogeriatric assessment, the prevention of pressure sores, and prevention of future falls and fractures. The audit highlighted that a concern was that only half of patients are now admitted to an orthopaedic ward within four hours of presentation. This figure stood at 56% (60.8% for the Trust) and that this had fallen when compared to 2011. <u>Action</u> The key recommendations and findings were reviewed. The report indicated that the Trust had reported a higher incidence of pressure ulcers than the national average. Following this a review of the data was undertaken. It was established that this

Report	Findings, Our Learning, & Our Actions
	was due to incorrect interpretation of the data requirements for the indicator and the data was resubmitted. The report also highlighted that the Trust had higher than average post-acute length of stay. As result a review the provision of step-down facilities was planned.

Appendix 4 . Local Clinical Audits – summary of learning & actions

The reports of 18 local clinical audits were reviewed by the provider in 2013-14 and Sandwell and West Birmingham NHS Trust intends to take the following actions to improve the quality of healthcare provided.

Audit topic	Actions identified
WHO Checklist Compliance Audit Audit description To assess the compliance with the "Five Steps to Safer Surgery" in the Trust. This includes use of the Surgical Safety Checklist.	Key findings/learning Results have shown that there is good compliance with the completion of the three sections on the Surgical Safety Checklist. Action Further work is required to ensure that a debrief session is recorded at the end of theatre lists.
Audit of the Management of Obstetric Patients with BMI >35 Audit description An audit of antenatal, intrapartum and postpartum maternal outcomes of women with a Body Mass Index (BMI) >35	Key findings/learning The audit found that 98% of the patients were seen by the consultant, and no anomalies were missed. 43% of the audit sample had pre-existing medical conditions, and 42% had complications during pregnancy. In addition that 97% of patients received postnatal chemothromboprophyalxis Action Actions included raising the awareness with all obstetric doctors of the need to prescribe chemothromboprophylaxis postnatally, so as to ensure that all eligible patients receive it.
Wire Accountability Audit Audit description The audit was conducted to assess practice following a clinical incident where a guide wire was retained post operatively.	Key findings/learning The audit highlighted the need for improve documentation of guide-wires removal in operation notes and for inclusion of this requirement in swab, needle and instrument counts. Action Action was taken to ensure that relavant surgeons document and account for insertion and removal

Audit topic	Actions identified
	of guide-wires in the Operation Notes and include this in swab and needle counts. In addition, to ensure that the outcome is included in the multidisciplinary (MDT) team record as a standard element. A subsequent reaudit has demonstrated an improvement in the recording of guidewire disposal and the review of this element at MDT meetings. A preprinted stamp also now been introduced to ensure that guidewire removal is addressed, and this will be added to the theatre care plan as a specific item at the next revision.
Management of recurrent epistaxis in the ENT Outpatient Department Audit description An audit to collect baseline data on the outcomes of patients with recurrent epistaxis.	Key findings/learning The audit found that.recurrent epistaxis was controlled almost totally in 93% of the cases audited. Patients would normally have one side cauterised and then brought back to the clinic in order to cauterise the other side, usually within 2 months. The audit found that a second visit was not necessary since both sides could safely be cauterised at the same visit. Action As a result of the findings action was taken to inform all ENT consultants that patients with bilateral recurrent epistaxis presenting to the ENT clinic can be successfully treated on a single clinic visit.
Audit of diagnostic and therapeutic laparoscopy complications Audit description A re-audit of laparoscopic entry and procedure related complications and to assess compliance with Royal College of Obstetrician & Gynaecologists (RCOG) guidelines (Green-top Guideline No. 49).	Key findings/learning The audit confirmed that there were no entry related complications in the cases reviewed, but that the documentation of other elements needed to be improved. Action. To improve documentation and to assist with re – audit, it was planned to introduce a standard pre-printed proforma for laparoscopic interventions. In addition, to stress the requirements in training and teaching of junior doctors in laparoscopic surgery and to re-audit in the second quarter of 2014/15.
Lumber spine Xrays in lower back pain. Audit description An audit to establish whether lumbar spine Xrays were being ordered appropriately according to	Key findings/learning The audit found that a high proportion of Xray requests were considered to be inappropriate according to best practice guidelines. Action To improve compliance, targeted dissemination of

Audit topic	Actions identified
national guidelines	information to GP practices would be undertaken and also consideration given to amending the electronic request form to indicate 'Not indicated in non-specific back pain'. A redudit to assess improvement would also be undetaken. .
Re-audit of the efficacy of intradetrusor botox in patients with refractory overactive bladder (OAB). Audit description. The audit aimed to confirm that Botulinum A Toxin is being used appropriately based on a trust approved checklist and also to compare findings with a previous local audit carried out in 2009.	Key findings/learning The results were found to be very similar to those from previous audit in 2009 and to the published literature. 86% of patients receiving intradetrusor botox fully complied with current trust guidelines. Action To use the audit findings in the consent process and to incorporate these into the Trust guidelines on the use of botox in the overactive bladder at the next review. In addition, to educate the team to ensure that all patients receiving botox for OAB comply with Trust guidelines and to re-audit in 2015.
An audit of the management of head injuries. Audit description To evaluate compliance within the ED's with the Head Injury guidelines as outlined by NICE and in ensuring that Head Injury Proformas are fully completed.	Key findings/learning The audit found that although there was good compliance with NICE requirements for imaging, it was not recorded for all patients whether they were triaged within 15 minutes of arrival or that they had a neurological assessment score (GCS) documented. In addition, the coagulopathy section was not always completed on the head injury proforma. Action Action was taken through educational reminders to ensure that all doctors fully complete the coagulopathy section and all other sections on the head inury proforma. In addition, to work with the nursing team to improve the documenting of the GCS score on triage and to monitor compliance through re-audit.
An audit of immunisation practice on the Neonatal Unit. Audit description The aim of the audit was to assess whether long stay infants on the Neonatal Unit receive their routine	Key findings/learning The audit found that all infants requiring 2-month and 3-month immunisations received them. 3 babies requiring 2 month immunisations did not receive them on time and there was a delay in obtaining parental consent in 2 cases.

Audit topic	Actions identified
childhood immunisations on time.	<u>Action</u> A redesign of computer generated paperwork was planned as a result. This would allow for a single point overview and as a reminder to teams for the need to document the need for immunisation and for obtaining parental consent.
Audit of the paediatric registrar review of admissions and of documentation on the post-take ward round <u>Audit description</u> An audit to assess compliance with Royal College of Paediatrics and Child Health standards for paediatric services (April 2011). This requires that every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a paediatrician on the middle grade or consultant rota within four hours of admission.	<u>Key findings/learning</u> The audit found a high compliance with the standards for the documentation of drugs, fluids and vital observations. Compliance was less for the documentation of all investigations (85%) and for the recording of parental (86%) and nursing (62%) concerns. In addition, the audit highlighted that improvements were required to ensure that every child is reviewed within 4 hours by a senior doctor. In the audit sample this was achieved in 86% of cases. <u>Action</u> The actions identified to improve compliance included ensuring that a nurse is allocated to be present on the ward round so that they can discuss concerns for each patient and to develop an electronic alert system to inform the team of the time that children have been waiting for review.
An audit of the Diabetic Renal Review Clinic. <u>Audit description</u> The aim of the audit was to measure outcomes in a nurse led diabetes renal review clinic through examining changes in key parameters (Blood pressure, HBa1c & urine ACR).	<u>Key findings/learning</u> The audit found that in an ethnically diverse population there was no significant change in HbA1c, BP or lipids over 1 year. There was a decrease in Urine ACR, but the number of patients was not large enough to attain statistical significance. . <u>Action</u> The actions identified included implementing a system to collect the data prospectively that would assist with re-auditing. Also, to have a dedicated nurse-led weekly review clinic for patients with diabetic nephropathy to ensure closer monitoring to improve outcomes.
Audit of the management of adult patients receiving home enteral feeding <u>Audit description</u> The aim of the audit was to review	<u>Key findings/learning</u> The audit found that all patients were seen within 1 month, but a yearly report to the GP was made in 86% of cases. <u>Action</u> The actions identified included establishing an alert

Audit topic	Actions identified
whether adults receiving home enteral feeds in Sandwell receive a defined level of care according to best practice guidelines. This included whether all patients were were reviewed within 1 month of a hospital discharge or community referral and whether a yearly report was made to GP.	via the electronic patient system (SystmOne) to highlight that a yearly report to a patients GP is due.
Re-audit of the compliance with the pulmonary rehabilitation elements contained in NICE Clinical Guideline 101- Chronic Pulmonary Disease Audit description A reaudit of patients with Chronic Obstructive Pulmonary Disease (COPD) referred to the Community Respiratory Service to assess the compliance with key standards and to assess whether there had been any improvements when compared to the previous audit.	Key findings/learning The audit found that 62% of all COPD patients referred to the service were offered pulmonary rehabilitation (PR). This was an improvement as this was only 40% in the previous audit.Of those offered pulmonary rehabilitation 61% accepted it. This was a 10% improvement compared to the previous audit. During the 3 month audit period the completion rate for patients commencing the programme was 62% Action To investigate further why patients are not offered pulmonary rehabilitation and to define limits to perceived constraints e.g. housebound patients and those with poor mobility. In addition, to provide the patient information leaflet upon assessment which will allow patients more time to consider the benefits of pulmonary rehabilitation.
Audit of the management of urinary incontinence in women Audit description The purpose of the audit was to identify if the Community Continence Service is adhering to NICE Clinical Guideline 40- Guidelines for the management of urinary incontinence in women. In particula, to assess whether a full continence assessment has been carried out which includes:- • Bladder diary completed by the patient • Urinalysis • Pelvic floor assessment • Written information given to	Key findings/learning The audit found that a bladder diary was completed by 78% of patients reviewed, but less than half of those reviewed had urinalysis documented. Lifestyle advice was provided in 74% of cases. Action To reinforce at team briefings the requirement to provide lifestyle advice to patients and to state the importance of bringing a urine sample on appointment letters.

Audit topic	Actions identified
pateints about lifestyle changes	
An audit of puerperal sepsis <u>Audit description</u> The audit was conducted in response to an outlier alert received from the Care Quality Commission (CQC) which had shown increased rates of infection.	<u>Key findings/learning</u> The review found that the alert followed heightened awareness around the early recognition of sepsis following a very robust sepsis campaign in 2011/12. Following this there was an improvement in the documentation of pyrexia and other indicators, leading to early implementation of the sepsis pathway. This is considered good practice as early diagnosis and treatment is known to significantly improve outcomes in cases of true sepsis. Whilst entirely appropriate, this evident improvement in documentation was considered to account for the increase in the number of women assigned a diagnostic codes from the puerperal sepsis bundle. The percentage of women, who were deemed by the clinical review team to have puerperal sepsis or wound infection (when expressed as a percentage of total deliveries) during the same period, appeared to be well below the national average. <u>Action</u> The review highlighted the need for clinicians assist coding practice by completing KMR forms prior to discharge. This would involve establish training needs to ensure that all clinicians (including midwifery staff) are equipped with the knowledge to do this) A further action was to re-audit a sample of cases of puerperal sepsis and obstetric wound infection to ensure that improvements have been made in appropriately coding cases.
Audit of elective caesarean section rates <u>Audit description</u> The audit was conducted in response to an outlier alert received from the Care Quality Commission, indicating a significantly higher than expected rates of elective caesarian section.	<u>Key findings/learning</u> The review found that some caesarean sections had been coded as elective procedures when in fact these had been conducted as an emergency. A review of a random sample of corectly coded elective sections found that all these were clinically appropriate and followed established pathways. <u>Action</u> Actions to ensure that the coding is accurate were identified. These included training of coding staff assigned to obstetrics and the development of a specific proforma to assist in the collection of accurate data.

Audit topic	Actions identified
A re-audit of adherence to Trust antibiotic guidelines on the Medical Assessment Unit (MAU). Audit description The aim of the audit was to establish whether antibiotic prescribing practice on the MAU was appropriate and in accordance with Trust guidelines.	Key findings/learning The re-audit revealed that although some improvements in antibiotic prescribing had been made when compared to the earlier audit e.g. adequate allergy status documentation, there were still some areas for improvement. Action A further re-audit is planned following the development of an E-learning package using the Quest System and the roll-out of an antibiotic App for smartphones.
An audit of the prescribing of oxygen. Audit description An audit to assess compliance with the British Thoracic Society (BTS) guideline for the emergency oxygen use in adults. In particular, with the requirement that oxygen should always be prescribed.	Key findings/learning The audit found that in the majority of cases in the sample audited the oxygen was not prescribed as required by the guideline. The guidelines make it clear that in an emergency situation oxygen should be administered first and then documented later. Action The actions identified included a review of the drug chart to make the prescription of oxygen a more prominent feature on the front page. In addition, to reinforce the need for oxygen to be prescribed in induction programmes and for pharmacists based in the Emergency Assessment Units (EAU's) to check whether oxygen has been prescribed along with other medications on their unit visits. Improvement to be monitored through re-audits.

Appendix 4. Supporting Data

4.1 Health and Social Care Information Centre

Health and Social Care Information Centre (HSCIC or IC) are England's national source of health and social care information collectors. Working with a wide range of health and social care providers nationwide to provide the facts and figures that help the NHS and social services run effectively. HSCIC collect data, analyse it and convert it into useful information. This helps providers improve their services and supports academics, researchers, regulators and policy makers in their work. Our aim is to ensure that the data and information the HSCIC provides is reliable and useful with the purpose of improving patient care and outcomes.

4.2 Summary Hospital – Level Mortality Indicator (SHMI)

The SHMI is a national mortality indicator launched at the end of October 2011. The intention is that it will complement the HSMR in the monitoring and assessment of Hospital Mortality. One SHMI value is calculated for each trust. The baseline value is 1. A trust would only get a SHMI value of 1 if the number of patients who die following treatment was exactly the same as the number expected using the SHMI methodology.

SWBH	Observed deaths	Expected deaths	SWBH	Band	National Average	National Lowest	National Highest
July 12- June 13	2184	2236	0.97	2	1.00	0.626	1.156
Oct 12 – Sept 13	2182	2184	0.98	2	1.00	0.88	1.11

4.3 Palliative care

Over the past couple of years the palliative care service has been developing. This service focuses on ensuring that people end their lives with a dignified death in the place of their choice and without pain.

SWBH	Denominator	Numerator	Rate of palliative care coding	National average	National Lowest	National Highest
July 12- June 13	2184	528	24.2	20.6	0	44.1
Oct 12 – Sept 13	2182	535	24.5	21.2	0	44.9

Palliative Care Coding

* The SWBH NHS Trust considers that this data is as described for the following reasons:

Actions have been in place over the past few years which is to do with the scrutiny of the HSMR, SHMI and reviews by the senior medical staff. SWBH remains in Band 2 and the HSMR and SHMI is below 100 using both indicators.

That the focus on developing the palliative care service has increased which has led to more patients being coded as on a palliative care pathway.

The SWBH NHS Trust has taken the following actions to improve this percentage and so the quality of its services by employing palliative care medical consultants and strengthen work across the acute and community services to develop better end of life care for patients.

Palliative care consultants and nurses are actively involved in the MQuAC which reviews a broad range of aspects of mortality including HSMR, SHMI, CQC alerts, incidents and internally identified concerns.

4.4 Patient Reported Outcome Measures

Percentage reporting improvement

	Health Status Questionnaire Percentage improving			
	Finalised data for April 11 – March 12 (Published October 13)		Provisional data for April 12- March 13 (Published February 14)	
	National	**SWBH**	**National**	**SWBH**
Hernia repairs	**51.0%**	**40.2%**	**50.2 %**	**50.0%**
Hip replacement	**87,5%**	**88.4%**	**89.7%**	**88.2%**
Knee replacement	**78.8%**	**71.8%**	**80.7%**	**72.7%**
Varicose vein surgery	**53.6%**	**61.0%**	**52.7%**	**43.8%**

Average adjusted heath gain

	Health Status Questionnaire Average adjusted health gain			
	Finalised data for April 11 – March 12 (Published October 13)		Provisional data for April 12- March 13 (Published February 14)	
	National	**SWBH**	**National**	**SWBH**
Hernia repairs	**0.087**	**0.047**	**0.085**	**0.088**
Hip replacement	**0.416**	**0.405**	**0.438**	**0.369**
Knee replacement	**0.302**	**0.247**	**0.319**	**0.271**
Varicose vein surgery	**0.095**	**0.100**	**0.093**	**0.053**

(orange)	SWBH below England average
(green)	SWBH above England average

The finalised data for 2011/12 and the provisional data for 2012/13 shows that there are areas where the reported outcome is below the average for England.

In response, SWBH has taken action the following action:

	Action taken
Hernia repairs	Work to ensure 80% questionnaires handed out. All patients seen and listed have been audited to ensure cases listed are symptomatic and have copies of letters. Consented appropriately. Risk and benefits explained. Introduction of Hernia clinic and listed, piloted and gradual roll-out from Feb 2014.
Hip & Knee replacement	Streamline questionnaire hand out process to ensure >80% uptake. A joint club in place and information leaflets given. Discussion with patients so they are fully aware of the risk and benefit as well as expected outcome. Audit of listing of Cases to ensure meets criteria consistently for replacement and meets the current CCG guidance. A contact point after discharge if there are any problems. A six month follow up and review of performance after surgery.
Varicose vein surgery	Most varicose veins are now done by radiofrequency ablation here. Questionnaire given on the day seen. Current wait times mean many of these are invalid and process has to be repeated. Current work is being undertaken to reduce wait time to ensure consistency. All patients have discussion regarding risk and benefits.

4.5 Readmissions

The tables below demonstrate that SWBH, based on the IC's most up to date data for adults of 16 years and over, had a higher than England average score for emergency readmissions to hospital within 28 days. For children, 0-15 years of age, the SWBH performance demonstrated a lower than England average readmission rate during the 4 year period illustrated. Over the 4 year period an increase rate of 28 day emergency readmissions was indicated in both groups. It is the most recent data available from the IC which gives us information about how we compare to others.

Readmissions 0-14 calendar year data

SWBH	Number of patients	Total number of re-admissions	Percentage of readmissions	National average	National Lowest	National Highest
11/12	14357	1621	9.89	4.19	0	19.7
10/11	14005	1486	9.41	4.21	0	29.5

Readmissions 15 and over

SWBH	Number of patients	Total number of re-admissions	Percentage of re-admissions	National average	National Lowest	National Highest
11/12	61494	7810	12.69	6.16	0	58.21
10/11	58587	7550	13.32	6.03	0	29.9

However, we are working to reduce emergency readmissions of all patients as a priority as described in section 2.16.

The IC's most up to date data, which we are required to report, used different definitions and age groups to generate their results. It does also not relate to the required reporting period (2013/14) which this Quality Account covers and has, therefore, could not be included.

* The SWBH NHS Hospital Trust considers that this data is as described for the following reasons:

The percentage of readmissions has increased, as shown in Table 25, as defined in patients between 0 and 14 years. The percentage of readmissions has increased, as shown in Table 26, in patients over 15 years during the defined period. We do intend to improve the position.

The SWBH NHS Hospital Trust intends to take the following actions to improve this number by taking the steps described in Section 2, 2.16 Focus Area 4- Reducing Emergency Readmissions, of this Quality Account, as we acknowledge that it is a high priority for improving patients' experience and the service we provide.

4.6 Responsiveness to the Personal Needs of our Patients

	SWBH	National Average	National Lowest	National Highest
2011-2012	70.8	67.4	56.5	85.0
2012–2013	66.9	68.1	57.4	84.4

Results for responsiveness to personal need questions

In addition, the IC provided average score from a selection of questions from the National Inpatient Survey measuring patient experience (Score out of 100).

* The SWBH NHS Trust considers that this data is as described for the following reasons:

Patient Experience is a high priority for the trust as can be seen in Part 2, 2.2. Our approach to patient experience is outlined in the patient experience plan – 'Patients Know Best' and will be driven through the executive Patient Experience Committee. The Trust has a good history of engagement with the people we serve and plans to continue doing so with a schedule of engagement and patient representative involvement interventions.

4.7 Friends and Family Test (FFT) Survey – Patient

The Friends and Family test asks service users , 'How likely is it that you would recommend this service to friends and family?'. It is based on a Department of Health Net Promoter Score (NPS)

methodology. It measures patients' perceptions of the quality of the health services they recently received. This assists the hospital in identifying both successes and problem areas. The Trust implemented the FFT survey programme in April 2012 . There has been a 3% increase in the strongly agree category with a lower number of patients participating in the survey.

SWBH	Inpatient Score	A&E Score	Combined FFT score	National average	National Lowest	National Highest
June 2013	67	50	58	63	25	100
March 2014	73	48	60	63	12	100

The score allocated is based on a calculation of the aggregation of the responses to various questions from the annual Survey, and is scored out of 100.

* The SWBH NHS Hospital Trust considers that this data is as described for the following reasons:

The data shows that between June 2013 and March 2014, the inpatient score has risen however the A&E score has dropped by 2 points. The combined score shows as a trust, we fall just below the National average in patients rating.

4.8 Friends and Family Test (FFT) Survey – Staff

NHS England have introduced Staff into FFT feedback from April 2014, this has been introduced nationwide and varies dependent on what type of provider the trust is. Ie. SWBH is an acute provider.

NHS England's vision for Staff FFT is that all staff should have the opportunity to feedback their views on their organisation at least once per year. It is hoped that Staff FFT will help to promote a big cultural shift in the NHS, where staff have further opportunity and confidence to speak up, and where the views of staff are increasingly heard and are acted upon.

SWBH	SWBH Strongly Agree/ Agree (%)	SWBH strongly disagree/ disagree (%)	Base number	National strongly disagree/ disagree (%)	National strongly Agree/ Agree (%)

The table below shows the results of one particular questions asked in the Staff survey, "would you recommend this organisation to a friend or family member?".

2013	59	9	305	27	65
2012	57	12	409	35	63

The table above represents the IC data with regard to the percentage of staff employed by or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends. This is summarised below:

The SWBH NHS Hospital trust intends to take the following actions to improve this performance by taking the steps described in Section 2 of this Quality Account, as it acknowledges that it is a high priority for improving patients' experience. Patient Experience is a high priority for the trust as can be seen in Part 2, 2.2. Our approach to patient experience is outlined in the patient experience plan – 'Patients Know Best' and will be driven through the executive Patient Experience Committee.

4.9 Venous Thromboembolism (VTE)

SWBH	Number of VTE Assessed Admissions	Total Admissions	Percentage of admitted patients risk-assessed for VTE	National average	National Lowest	National Highest
Feb 13	7844	8615	91.1%	94.1%	86.9%	100%
Feb 14	8158	8272	99%	96%	100%	100%

Data source- Health & Social Care Information Centre (IC)

*The SWBH NHS Hospital Trust considers that this data is as described for the following reasons:

The trust set up a new clinical system to record VTE using Junior Doctor implemented configuration to be user friendly and accessible during admission process. An indicator has been added to the electronic bed boards in every ward which show when VTE assessments are required.

The SWBH NHS Hospital trust intends to take the following actions to improve this number by taking the steps described in Focus Area 2 in Part 2 of this Quality Account, as it acknowledges that it is a high priority for improving patients' safety.

In addition, the clinically led Thrombosis Group meet bi-monthly to address issues relating to VTE risk assessment management, amongst other clinical issues, and is reviewing hospital associated incidences of embolus. This group reports to the Clinical Effectiveness.

4.10 Clostridium difficile (C-diff)

*SWBH NHS Hospital Trust considers that this data is as described for the following reasons:
During the reporting periods in the table below, the Trust then implemented stringent infection control measures and has continued to maintain a high level of vigilance and activity of infection control, as described in this section of the Quality Account.

It can be observed in the table below that the rate of infection per 100,000 bed days has decreased from 21.5 in 2012 to 17.3 in 2013. Our performance has improved thru 2013/14 as described above.

SWBH	Trust rate	National Average	National Lowest	National Highest
11/12	33.0	22.2	0	38.1
12/13	15.2	17.3	0	35.2

C.Diff performance is described in terms of rate per 100,000 bed days for specimens taken from patients aged 2 years and over, using the IC data.

SWBH intends to take the following actions to continue the decrease in C.Diff cases by achieving hand hygiene standards, complying with CQC standards and maintaining Patient Environment Action Team (PEAT) scores at a good level.

4.11 Patient Safety incidents

Patient safety holds a large focs in the trust, this is discussed in great deal in the main body of the quality accounts, and you can find this in section 3.2.

	SWBH rate	National Average	National Lowest	National Highest
Oct 12 – March 13	9.8	16.4	179.1	1.7
12/13	9.4	14.8	174.2	2.0

Appendix 5. Auditors Limited Assurance report

To follow

SWBTB (6/14) 080 (c)

2013/14: External assurance on your quality account

Sandwell and West Birmingham Hospitals NHS Trust

May 2014

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- Scope of work performed and approach
- Recommendations raised
- Follow up of prior year recommendations
- 2013/14 Limited Assurance Opinion on the content of the Quality Account and performance indicators
- Responsibilities of the Board of Directors and limitations associated with this engagement

Important notice

This report is addressed to Sandwell and West Birmingham Hospital sNHS Trust (‘the Trust’) and has been prepared for your use only. We accept no responsibility towards any member of staff acting on their own, or to any third parties. The Audit Commission has issued a document entitled Statement of Responsibilities of Auditors and Audited Bodies. This summarises where the responsibilities of auditors begin and end and what is expected from the Trust. We draw your attention to this document.

External auditors do not act as a substitute for the Trust’s own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

If you have any concerns or are dissatisfied with any part of KPMG’s work, in the first instance you should contact Andrew Bostock, who is the engagement lead to the Trust, telephone 07796 313249 or email andrew.bostock@kpmg.co.uk who will try to resolve your complaint. If you are dissatisfied with your response please contact Trevor Rees on 0161 246 4000, or by email to trevor.rees@kpmg.co.uk, who is the national contact partner for all of KPMG’s work with the Audit Commission. After this, if you are still dissatisfied with how your complaint has been handled you can access the Audit Commission’s complaints procedure. Put your complaint in writing to the Complaints Unit by phone (0303 444 8330), by email (complaints@audit-commission.gsi.gov.uk), through the Audit Commission website (www.audit-commission.gov.uk/about-us/contact-us) or via post to The Private Secretary, Controller of Audit’s Office, Audit Commission, 3rd Floor Fry Building, 2 Marsham Street, London, SW1P 4DF.

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Headlines

Introduction

In early 2014, the Audit Commission released their ‘Auditor Guidance 2013/14’. This document provides an overview of the external assurance requirements for the Quality Account and forms the basis for our approach to reviewing your Quality Account and performing testing over performance indicators. The output of our work is a ‘limited’ assurance opinion.

Conclusion

You have achieved a **limited assurance** opinion (see Appendix C) on whether anything has come to our attention which leads us to believe that:

- your quality account does not comply with the Quality Accounts regulations;
- your quality account is not consistent with specified documentation; and
- either or both of the indicators we have tested is misstated.

Key findings

Our work is substantially complete, subject to receipt and verification of statements from Commissioners and the local Healthwatch organisation. Upon receipt of these, we will carry out final checks to ensure you have reflected our comments in the Quality Account and to review changes made by the Trust after the date of this report. We have set out the key headlines from our work below.

Content – the content of your Quality Account addresses the regulations of the QA regulations

The content of the Quality Account addresses the regulations of the Quality Account regulations.

We noted minor matters concerning the availability of specified information for certain prescribed indicators and presentation of the information included in the early draft of the Quality Account which was presented to Audit Committee on 24 April 2014.

We formally received the draft for audit on 22 May 2014 in line with the Trust’s timetable. The Trust has substantially addressed the omissions identified as part of our initial review. We have fed back our comments in terms of the structure of the document to make the content more accessible to the reader. We have suggested that the Trust reallocate several sections, such as the Statement of Directors responsibilities, to make the relevant content more prominent and that the Annual Governance Statement is excluded as a separate document in its own right.

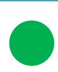
See section one for our detailed findings.

Indicator 1: Rate of clostridium difficile infections;

We did not identify any issues that impact on our ability to issue a limited assurance opinion in respect of this indicator.

See section two for our detailed findings.

Consistency – the content of the Quality Account is not inconsistent with other information sources specified by the AC in their 2013/14 Guidance



We reviewed the information sources specified in the ‘Auditor guidance 2013/14’ issued by the Audit Commission and identified that:

- Significant matters in the specified information sources were reflected in the Quality Account where appropriate; and
- Significant assertions in the Quality Account were supported by the specified information sources.

We are still awaiting the feedback from stakeholders, which was not requested from the local healthwatch organisation in a timely manner.

See section one for our detailed findings.

Indicator 2: Percentage of patients risk-assessed for venous thromboembolism (VTE);

We did not identify any issues that impact on our ability to issue a limited assurance opinion in respect of this indicator.

See section two for our detailed findings.

Key

- Green: No issues/ minor areas of improvement identified
- Amber: Opportunities to improve
- Red: Significant issues identified which impact on your opinion

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Report structure and next steps

Recommendations raised

We have raised three recommendations as a result of our work which are included in Appendix B, none of which are high priority. The Trust excluded indicators requiring inclusion within 2013/14 Quality Accounts within the draft version, which were consistent with those required in 2012/13. The Trust should incorporate the prescribed information within its regular quality reporting to embed the extraction of relevant data into Quality Account production processes. In addition, the Trust should develop its integrated reporting timetable for the year end production of the Annual Report, Quality Report and accounts.

We have followed up prior year recommendations and concluded that of the two recommendations raised, one has not been implemented. The Trust has been unable to provide a copy of the Annual Complaints report which should be published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009. We are required to review this as part of the specified information sources we have to ensure are reflected in the Quality Account

Structure of this report

The remaining sections of this report cover the:

- Detailed findings: Content of the Quality Account – section one outlines the work we performed, summarises our findings and concludes on whether a limited assurance opinion has been issued; and
- Detailed findings; our review of two selected performance indicators– section two summarises our work performed on the two mandated indicators subject to a limited assurance report specified by the Audit Commission. It concludes on whether a limited assurance opinion has been issued for the mandated indicators.

Next steps to conclude the 2013/14 Quality Account assurance process

1) The Trust needs to provide its Statement of Directors' Responsibilities in respect of the Quality Account (see Appendix E of this report for the responsibilities of Directors in relation to the Quality Account). The Trust should ensure that this is consistent with the disclosures made in the AGS in respect of data quality issues during the year.
2) Trusts are required to publish their Quality Account on the NHS Choices website and submit it to the Secretary of State for Health by 30 June 2013. To meet this deadline, we will provide our opinion by 9 June 2013.
3) The Trust needs to include our limited assurance opinion on the content of the Quality Account and the mandated indicators (see Appendix D) in the Annual Report which the Trust will submit to the Department of Health on 30 June 2013.

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Detailed findings – Content of the Quality Account

Conclusion

Subject to carrying out our final checks to ensure you have reflected our comments in the Quality Account and reviewing changes made by the Trust after the date of this report, we are satisfied that there is sufficient evidence to provide a limited assurance opinion on the content of the Quality Account.

We have raised three recommendations to address the issues noted in this section, which are detailed in Appendix B.

We have included our opinion in Appendix D to this report.

Work performed and findings

In this section, we report our work on the content of the Quality Account against two criteria:

1) A review of content to ensures it addresses the requirements of Quality Accounts Regulations; and
2) A review of content in the Quality Account for consistency with the content of other information specified by Audit Commission in its ‘Auditor Guidance 2013/14’.

We have set out in more detail the scope of this work in Appendix A.

1) Content addresses requirements of the Quality Account Regulations

We reviewed the content of the Quality Account against the Quality Account Regulations. We undertook an early review of the draft Quality Account that was presented to the Audit Committee on 24 April 2014. We identified a number of omissions to the Project Coordinator in the Medical Director’s Team. These included the data made available to the Trust by the Information Centre with regard to the core indicators to be included in the 2013/14 quality accounts. These were set out in Appendix 2 of the letter dated 9 January 2014 in relation to Quality Account reporting arrangements 2013/14 issued jointly by NHS England, Monitor and the NHS Trust Development Agency.

This included the requirement to express one of the mandated indicators selected for testing, the rate per 100,000 bed days of cases of C difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.

The Trust has subsequently incorporated these as part of the Quality Account draft seven presented for audit on 22 May 2014 in line with the Trust’s timetable. Upon review we suggested a number of improvements to the structure of the Quality Account, whilst maintaining the prescribed structure set out in the Quality Account regulations, in order to enhance the prominence of the information relevant to users. This included reallocating responsibility statements and limited assurance reports to the rear of the quality account..

2) Consistency of Quality Account content with specified other information

We were required to review the consistency of the Quality Account against specified information. Our findings are set out below:

Issues considered	Findings
Are significant matters in the specified information sources reflected in the Quality Account?	We identified that the Trust reflected its significant matters, relevant to the selected priorities from the specified information sources, in its Quality Account. The latest available draft of the quality account is largely complete, although we note that management is awaiting statements from commissioners and Healthwatch organisations which are required to be incorporated within the final draft. The Trust did not meet the requirement to send a copy of its quality account to the Local Healthwatch organisation by 30 April 2014 for their comments. We have raised a recommendation in Appendix B for the Trust to add this to its detailed timetable for 2014/15.

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Detailed findings – Content of the Quality Account (cont.)

Issues considered	Findings
Are significant assertions in the Quality Account supported by the specified information sources?	Significant assertions in the Quality Account are supported by the relevant information sources. We were able to agree performance for indicators to internal reports and could confirm other assertions to a variety of relevant sources including external reports, stakeholder statements and examples of patient feedback. As part of our review of specified information sources, we are required to review the quality account to ensure it is not materially inconsistent with the Annual Governance Statement (AGS). As auditors we are required to consider the implications for our limited assurance report if internal control and data quality issues reported in the AGS are not reflected in the statement of responsibilities. The Trust states within its AGS that it has "identified a number of further issues on data quality and accordingly established a Board level taskforce to tackle the subject, with advice from our incoming auditors and with involvement from commissioners. This has made good progress both in creating standard operating protocols for data and in establishing a data quality kite-mark for information". It concludes with the Accounting Officer stating that he is satisfied both that the Trust's reported data (where the source data is from the Trust) is materially accurate and that the Trust has a good basis for future data quality control. The Trust should consider whether the issues reported in the AGS require reflection in the statement of responsibilities.

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Detailed findings: our review of two selected performance indicators

Introduction

We carried out work on two indicators, chosen by the Trust from a list of four available indicators as specified by the Audit Commission in its guidance:

1. Percentage of patients risk-assessed for venous thromboembolism (VTE); and
2. Rate of clostridium difficile infections.

We have set out in more detail the scope of this work in Appendix A.

Conclusion

Our work on this indicator requiring a limited assurance report suggests there is **sufficient evidence to provide a limited assurance opinion** in respect of both of the indicators selected by the Trust. We have included our opinion in Appendix D to this report. Please note that the extent of the procedures performed is reduced for limited assurance. The nature of the procedures may be different and less challenging that those used for reasonable assurance. Therefore, our work was not a reasonable assurance audit of either the performance indicators or the processes used to collate and report them

Results of our work

We have set out overleaf the key findings from our work as described above in relation to the two selected indicators.

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Detailed findings: Our review of two selected performance indicators (1)

<table>
<tr><th>Indicator</th><th>Area of our work</th><th>Key findings</th><th>Overall conclusion</th></tr>
<tr><td rowspan="3">Percentage of patients risk-assessed for venous thromboembolism (VTE)
Definition:
Numerator: Number of adults admitted to hospital as inpatients in the reporting period who have been risk assessed for VTE according to the criteria in the national VTE risk assessment tool during the reporting period.
Denominator: Total number of adults admitted to hospital in the reporting period.
Performance as at 31 March 2014: 98.7%
Target: 95%</td><td>Definition and guidance</td><td>We did not identify any improvements required with regard to the Trust’s understanding and application of the guidance associated with and the definition of the indicator.
We did not identify any issues relating to the six specified dimensions of data quality in this area of our work. We note that the Trust’s Internal Auditors raised a recommendation in their VTE review dated April 2014 to develop an Administrative VTE Policy and Standing Operating Procedure for the undertaking of VTE assessments and have not replicated this recommendation as part of our work.</td><td rowspan="3">We have not identified any issues which impact our overall opinion.</td></tr>
<tr><td>Trust systems to produce the indicator</td><td>We did not identify any improvements required with regard to the systems and processes the Trust uses to produce the indicator.
We did not identify any issues relating to the six specified dimensions of data quality in this area of our work.</td></tr>
<tr><td>Substantive testing</td><td>VTE assessments can be completed using either the iSOFT Clinical Manager (iCM) function through the Patient Administration System (PAS) or through the Electronic Bed Management System (eBMS).
Of 25 records, there were 20 which required a VTE assessment and the assessment was correctly captured on the system in 100% of cases.
We did not identify any issues relating to the six specified dimensions of data quality in this area of our work</td></tr>
</table>

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Detailed findings: Our review of two selected performance indicators (2)

Indicator	Area of our work	Key findings	Overall conclusion
Rate of Clostridium difficile infections ("CDIs") per 100,000 bed days for patients aged two or more on the date the specimen was taken during the reporting period **Definition:** **Numerator:** The number of CDIs identified within a trust during the reporting period. **Denominator:** The number of bed days (divided by 100,000) reported by a trust during the reporting period. **Performance as at 31 March 2014:** 39 cases (15.2 per 100,000) **Target:** 46 cases	Definition and guidance	We did not identify any improvements required with regard to the Trust's understanding and application of the guidance associated with and the definition of the indicator. We did not identify any issues relating to the six specified dimensions of data quality in this area of our work. We have raised a recommendation in Appendix B for the Trust to ensure that it incorporates all core indicators required within the Quality Account at the stage the first draft is produced and circulated to stakeholders by 30 April 2014. This includes this indicator, which has subsequently been disclosed.	**We have not identified any issues which impact our overall opinion.**
	Trust systems to produce the indicator	We did not identify any improvements required with regard to the systems and processes the Trust uses to produce the indicator. We did not identify any issues relating to the six specified dimensions of data quality in this area of our work.	
	Substantive testing	Of 25 records traced back to microbiology screening, the result of the C. Difficile screening test was captured on the system and in the patients' notes in 100% of cases. Only those positive tests performed at least for days post admission were reported as being hospital acquired which meets the definition. We did not identify any issues relating to the six specified dimensions of data quality in this area of our work.	

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Scope of work performed and our approach

Background

In early 2014, the Audit Commission released their 'Auditor Guidance 2013/14'. This document provides an overview of the external assurance requirements for the Quality Account.

The publication of *High Quality Care for All* in 2008 placed quality and quality improvement at the heart of current debate in the NHS. The Health Act 2009 and associated regulations require all providers of NHS healthcare services in England to publish a Quality Account each year about the quality of NHS services they deliver

Since 2010/11, the Department of Health has required external assurance over the Quality Account in some form. The requirements have evolved over time and have become increasingly aligned with Monitor's requirements for Foundation Trusts. There have not been any fundamental changes in our approach to reviewing the content and consistency of the quality Account in 2013/14. However, the Trust has been given greater flexibility to select indicators for review.

Scope, approach and outputs

Our work has been based on the principles of ISAE 3000 (*Assurance Engagements other than Audits and Reviews of Historical Financial Information*) in order to provide an independent assurance opinion. We have set out our approach below

Requirement	Approach	Output
Review the content of the Quality Account against the requirements specified by the Quality Accounts Regulations	■ Desktop review of the Trust's Quality Account against the checklist of requirements as set out in the Audit Commission guidance. This work addressed: – Significant matters in the specified information sources relevant to the priorities selected by the Trust for the Quality Account to be reflected in the Quality Account; and – Significant assertions in the Quality Account to be supported by a suite of specified information sources.	**Limited assurance opinion over**: ■ Compliance with the regulations ■ Consistency with specified documentation ■ Two indicators in the quality account
Review the content of the Quality Account for consistency against the other information sources detailed in the Audit Commission guidance.	■ Desktop review of the Trust's Quality Account against the Trust's file of evidence.	
Testing of two indicators agreed with the trust	■ In its guidance, the Audit Commission has specified a testing strategy. This requires us to: – confirm the definition and guidance used by the NHS trust to calculate – the indicator; – document and walk through the NHS trust's systems used to produce the indicator; and – undertake substantive testing on the underlying data against six specified data quality dimensions.	

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Recommendations

We have raised three recommendations.The Trust has agreed to the recommendation and has provided management responses. We will follow up these actions during 2014/15.

We have followed up those recommendations raised in 2012/13 in Appendix C.

High priority	Fundamental issues which have resulted or could result in a qualification of the limited assurance opinion and require immediate action	Medium priority	Improvements which are required but may not need immediate action. In isolation this issue may not prevent an assurance opinion being issued but it may contribute to a group of issues that could prevent an assurance opinion being sought	Low priority	Minor improvements which, if corrected, would benefit the organisation but would not in isolation be likely to prevent an assurance opinion being sought

#	Priority	Issue and Recommendation	Management Response	Responsible Officer/Due Date
1	Medium	***Inclusion of Mandated indicators*** The joint letter from NHS England, Monitor and NHS Trust Development Agency issued to all Trusts on 9 January 2014 set out those indicators requiring inclusion within 2013/14 Quality Accounts. These were consistent with those required in 2012/13, but were excluded from early drafts of the Trust's 2013/14 Quality Report, including the draft shared with the Audit Committee and Commissioners. *Recommendation* The Trust should incorporate the prescribed information within its regular quality reporting to embed the extraction of relevant data into Quality Account production processes. This will alert the Trust to any trends and deviations from national best performance ahead of the data being published as part of the year end Quality Account.	The relevant indicators will be incorporated into the monthly Integrated Quality, Performance and Finance Report going forward. Not all of these indicators are reported monthly some of them are returns from annual surveys which are reported in the relevant forums in the Trust.	**Responsible Officer:** Head of Performance **Due Date:** June 2014

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Recommendations (cont.)

#	Priority	Issue and Recommendation	Management Response	Responsible Officer/Due Date
2	Medium	***Document assurance by other parties*** The Quality Account regulations require Trusts to send a copy of its quality account to the following organisations by 30 April 2014 for their comments: ■ NHS England or relevant CCG; ■ the appropriate Local Healthwatch organisation; and ■ the appropriate Overview Scrutiny Committee. A statement from each, if offered, must be presented in the quality account. Whilst the Trust prepared a timetable for the production of the Quality account in 2013/14 following our debrief of the process in 2012/13, the requirement to issue to the local healthwatch organisations was omitted in error. *Recommendation* The Trust should build on the timetable developed for the 2013/14 process and ensure all relevant feedback is scheduled in a timely manner.	We will ensure that submission to the local Healthwatch committee is included in the timetable for the 14/15 Quality Account.	**Responsible Officer:** Medical Director **Due Date:** February 2015
3	Low	***Interaction with Annual Report*** As part of our review of the Quality Account we raised a number of observations regarding the structure of the account. This included the requirement for the Annual Governance Statement to sit outside of the Quality Account as a document in its own right, within the Trust's overall Annual Report. The deadline for upload of the Quality Account to the NHS Choices website is currently 30 June, which is currently scheduled later than the accounts and annual reporting deadline of 9 June. There is a degree of interaction and potential overlap of some content between the Annual Report and Quality Account and the potential for earlier reporting deadlines in 2014/15 in line with Foundation Trusts. *Recommendation* The Trust should develop an Integrated Annual Report, Quality Account and financial statements timetable to clearly set out roles and responsibilities and ensure the document is structured in a favourable way to engage the reader.	This year's Quality Account and Annual Report will have a common theme and format when published. A timetable that aligns the publication of these reports will be created for 14/15.	**Responsible Officer:** Head of Communications **Due Date:** February 2015

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Follow up of prior year recommendations

In 2012/13, we raised two recommendations.

in the table below, we have set out the recommendation which has not been fully implemented by the Trust.

#	Priority	Issue and Recommendation	Management Response and due date	Status as at May 2014
1	Medium	**Consistency of the Quality Account with "other information"** We note that we have not had access to one of the information sources that we are required to consider under the Audit Commission guidance as we have not been provided with a copy of the Trust's Annual Complaints report. We cannot therefore comment on the consistency of the Quality Accounts with this information source. ***Recommendation*** The Trust should ensure that it produces and publishes an annual complaints report under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009.	An Annual Complaints report is being produced at the moment as part of a risk/governance Annual Report. We will continue to provide information and data for the Quality Report on a monthly basis and will produce an Annual Report yearly from now on. **Responsible officer:** Alison Binns **Due date:** 30 September 2013	We have not been provided with a copy of the Annual Complaints Report. The Assistant Director of Governance is currently in the process of writing the Annual Complaints report along with Risk and Legal reports with a deadline of 30 June. As such we have not considered the consistency with this document as part of the review of specified information sources. The Trust will look to advance its timetable to produce the report to meet this regulation in 2014/15.

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2013/14 Limited Assurance Opinion on the content of the Quality Account and performance indicators

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required by the Audit Commission to perform an independent assurance engagement in respect of Sandwell and West Birmingham Hospitals NHS Trust's Quality Account for the year ended 31 March 2014 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 ("the Act"). NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for veneous thromboembolism (VTE); and
- Rate of clostridium difficile infections.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

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2013/14 Limited Assurance Opinion on the content of the Quality Account and performance indicators

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2013/14 issued by the Audit Commission on 17 February 2014 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2013 to June 2014;
- papers relating to the Quality Account reported to the Board over the period April 2013 to June 2014;
- feedback from the Commissioners dated XX/XX/2014;
- feedback from Local Healthwatch dated XX/XX/2014;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated XX/XX/20XX;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated XX/XX/2014;
- the latest national staff survey dated XX/XX/20XX;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated XX/XX/2014;
- the annual governance statement dated XX/XX/2014;
- Care Quality Commission quality and risk profiles/intelligent monitoring dated XX/XX/2014;
- the results of the Payment by Results coding review dated XX/XX/2014; and
- [any other relevant information included in our review.]

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

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2013/14 Limited Assurance Opinion on the content of the Quality Account and performance indicators

This report, including the conclusion, is made solely to the Board of Directors of Sandwell and West Birmingham Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Sandwell and West Birmingham Hospitals NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of our appointment under the Audit Commission Act 1998 and in accordance with the Commission's Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- [analytical procedures];
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Sandwell and West Birmingham Hospitals NHS Trust..

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2013/14 Limited Assurance Opinion on the content of the Quality Account and performance indicators

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

KPMG LLP, Statutory *Auditor*

One Snowhill,

Snow Hill Queensway

Birmingham, B4 6GH

6 June 2014

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Responsibilities of the Board of Directors and limitations associated with this engagement

- We have performed procedures designed to assess the content of the Quality Account in order to be able to provide a 'limited assurance' opinion. Where an opinion has been issued, we have carried out sufficient work to ensure that there is nothing that has come to our attention in the Quality Account that is not inconsistent with other information as specified in the Audit Commission's 'Auditor Guidance 2013/14'. This is not as detailed as providing a reasonable assurance opinion because we have only been required to review a limited amount of information. We have set out this limited information in section one.
- Procedures designed to assess readiness for a 'limited assurance' opinion on the mandated indicators requiring a limited assurance report are not as detailed or as challenging as those designed for 'reasonable assurance'. A limited assurance opinion on a performance indicator does not mean that indicator has been confirmed as accurate only that, based on the limited procedures performed including identification of controls and walkthroughs of systems nothing has come to our attention to suggest the indicator is inaccurate.
- Some indicators carry an inherent uncertainty which means you and we need to note that uncertainty when we comment on the indicator. For indicators like this in future periods, we will ask you to explain that inherent uncertainty in your reporting and we will include a 'matter of emphasis' in our opinion on that indicator. We will bring you more information on this as we plan the approach for 2014/15.

The Statement of Directors' Responsibilities in respect of the Quality Accounts outlines the directors' responsibilities under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 in preparing Quality Accounts and the expectations of the Department of Health. This work, and any subsequent work to provide an assurance opinion in future periods, is not a substitute for these responsibilities which remain with the Board of Directors of the Trust.

As set out in the Executive Summary 'next steps' paragraph, we will require a signed Statement of Directors' Responsibilities before we issue any opinion.

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The information contained herein is of a general nature and is not intended to address the circumstances of any particular individual or entity. Although we endeavour to provide accurate and timely information, there can be no guarantee that such information is accurate as of the date it is received or that it will continue to be accurate in the future. No one should act on such information without appropriate professional advice after a thorough examination of the particular situation.

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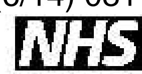
Sandwell and West Birmingham Hospitals 
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Capital Programme 2014/15
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance and Performance Management
AUTHOR:	Chris Archer, Associate Director of Finance - Corporate
DATE OF MEETING:	5 June 2014

EXECUTIVE SUMMARY:

Key messages:

- Report proposes the updated capital programme of £19.155m for 2014-15 be approved. It sets out the programme in detail, how the programme is funded, identifies risks associated with the programme and how the programme will be monitored & managed
- The plan is grounded in the plan approved as part of the LTFM in November 2013 and has been subject to detailed review and update. £2.1m remains in contingency / available for strategic investment.
- The programme is funded from additional Public Dividend Capital (PDC) from the Department of Health in relation to specific IM&T schemes of £571,000, charitable donations of £84,000; depreciation funding generated by operating margin of £14.0m with the balance of £4.5m being a reduction in the Trust's accumulated cash balances.
- The Trust's Capital Resource Limit requirement is £19.1m, being that balance of the programme not funded by charitable donations.
- Risks associated with the programme include limited funding for wider estates and IM&T schemes and for imaging equipment. These will be kept under review in particular as the longer term capital programme is reviewed in the next two months.
- The funding vehicle for the catheter laboratory will be subject to review since a managed service scheme may provide better value for money. Similar consideration will be given to relevant IM&T & transport schemes.
- The programme will be routinely monitored and managed through a group of lead responsible persons and chaired by the Director of Finance.
- Finance and Investment Committee will receive a monthly update on progress against the programme.

REPORT RECOMMENDATION:

The Trust Board is asked to accept the Finance & Investment Committee's recommendation that the Capital Plan 2014/15 be approved.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	x	

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***					
Financial	**x**	Environmental	**x**	Communications & Media	
Business and market share		Legal & Policy	**x**	Patient Experience	**x**
Clinical	**x**	Equality and Diversity		Workforce	
Comments:					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Good use of Resources

PREVIOUS CONSIDERATION:
Finance & Investment Committee and Performance Management Committee.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report to Trust Board on 5th June 2014

CAPITAL PROGRAMME 2014-15

1 EXECUTIVE SUMMARY

1.1 This report proposes an updated capital programme of £19.155m for 2014-15 be approved by the Trust Board. It sets out the programme in detail, how the programme is funded, identifies risks associated with the programme and how the programme will be monitored.

2 PROPOSED PROGRAMME

2.1 The proposed programme totals £19.155m and is summarised at appendix 1. The plan is grounded in the capital plan set out in the LTFM of November 2013 and has been subject to a detailed review and update. £2.1m is identified as being available for contingency / strategic investment cases.

2.2 The indicative phasing of the plan is set out in appendix 2. £1.5m (8%) in Q1, £3.4m (18%) in Q2, £6.2m (32%) in Q3 and £8.0m (42%) in Q4 which includes £2.1m contingency. This indicative phasing shall be subject to routine review & challenge & with a view to accelerating schemes where there is service or financial benefit.

3 FUNDING OF THE PROGRAMME

3.1 The capital cash funding plan is set out in appendix 3. The programme is funded from internally generated funds (depreciation from delivery of operating margin) of £14.0m, additional Public Dividend Capital (PDC) from the Department of Health in relation to specific IM&T schemes of £571,000, charitable donations of £84,000, with the balance of £4.5m being a reduction in the Trust's accumulated cash balances.

The Trust's Capital Resource Limit requirement is £19.1m, being that balance of the programme not funded by charitable donations and recognising the additional PDC drawdown.

3.2 The catheter laboratory may be provided under a managed service contract subject to VFM & affordability tests. An assessment shall also be made as to the appropriate accounting treatment in respect of on / off balance sheet and consequent count against capex & CRL. Similar consideration may apply to telecoms / data centre and vehicle replacement schemes.

4 RISKS

4.1 The estates elements of the proposed programme provide de-minimis resources consistent with maintaining a safe and resilient infrastructure. As such they provide limited flexibility to support CIP enabling. There will be an on-going prioritisation review should such proposals arise during the year.

There is no specific provision to advance retained estate reconfiguration in 2014/1. This may be a call on the contingency / strategic investment element of the plan.

4.2 A forward replacement programme for imaging remains to be completed. There is no provision in the proposed plan for 'big ticket' replacement [catheter laboratory aside]. 'Small ticket' replacement shall be prioritised against other medical equipment requirements.

4.3 The programme for IM&T focuses on schemes to support the Year of Outpatients. There is no specific provision for the development & implementation of schemes associated with an Electronic Patient Record. This may be a call on the contingency / strategic investment element of the plan.

4.4 Each of the above risks will be kept under review and taken into consideration when the longer term capital programme for 2015-2020 is reviewed in the next three months.

4.5 Routine assessment of the revenue consequences of capital schemes will be kept under review.

5 PROGRAMME MONITORING & MANAGEMENT

5.1 Routine monitoring and management of the programme has been re-established as a group of the lead officers under the chairmanship of the Director of Finance and Performance. This shall routinely include a forecast of delivery and recommendation of virement to effectively manage capital taking one year with another.

5.2 Finance and Investment Committee will receive a monthly update on progress against the programme as part of routine financial reporting.

5.3 Approval of schemes and any relevant business cases shall be undertaken in line with the Trust's Scheme of Delegation.

6 RECOMMENDATION(S)

6.1 The Board is asked to accept the Finance & Investment Committee's recommendation that the capital plan 2014/15 be approved.

Tony Waite, Director of Finance and Performance

30 May 2014

Appendix 1

Sandwell & West Birmingham Hospitals NHS Trust

SUMMARY CAPITAL PROGRAMME 2014/15

Outturn 2013/14 £000's	LTFM 2014/15 (Nov 13) £000's	TDA Plan 2014/15 £000's	Accountable Executive Director	Responsible Manager	CAPITAL PROGRAMME Year to date: April 2014	Budget Book £000's	Updates to Plan £000's	Revised Plan £000's
					CAPITAL FINANCING			
19,795	18,290	20,760	TL	CA	Original CRL excluding additional PDC	20,760	(2,260)	18,500
1,409		571	TL	CA	Original additional PDC	571	0	571
			TL	CA	In year additional PDC	0	0	0
			TL	CA	Other adjustments	0	0	0
213		84	TL	CA	Grants & Donations	84	0	84
21,417	**18,290**	**21,415**			**TOTAL CAPITAL FINANCING**	**21,415**	**(2,260)**	**19,155**
					CAPITAL PROGRAMME			
0	0	2,000	TW	CA	Slippage and retentions	2,000	(1,755)	246
4,998	2,800	2,015	GS	RB	Land Acquisition / Demolitions	2,015	985	3,000
3,444	3,000	3,000	GS	RB	Statutory Standards	3,000	(1,500)	1,500
0	2,000	2,780	GS	RB	Retained Estate Refurb - electrical infrastructure	2,780	(780)	2,000
5,204	0	0	GS	RB	Estates rationalisation / Energy Efficiency	0	500	500
0	0	0	GS	RB	Other Estates related schemes	0	59	59
3,090	3,000	3,000	AM	LB	Medical Equipment	3,000	(1,000)	2,000
935	0	424	CO	SC	Maintenance Capex - Other	424	(224)	200
1,067	0	0	AM	JM	Imaging	0	0	0
0	0	0	GS	RB	Catheter Lab	0	2,150	2,150
0	0	0	AM	LB	Bowel Cancer Screening	0	222	222
1,669	2,000	2,000	RS	FS	IM&T - Year of Outpatients	2,000	(1,000)	1,000
0	3,490	3,492	RS	FS	IT and Telecomms - Phone exchange / data centre	3,492	(1,992)	1,500
0	0	499	RS	FS	PACS / VNA	499	900	1,399
535	0	72	RS	FS	VitalPAC (Better Hospitals element)	72	0	72
0	0	0	RS	FS	Other IM&T schemes	0	596	596
475	500	0	GS		Capitalised Salaries	0	500	500
0	1,500	2,049	TL / TW		Strategic Investments / Contingency	2,049	79	2,128
0	0	84	AM		Donated assets	84	0	84
21,417	**18,290**	**21,415**			**TOTAL CAPITAL PROGRAMME**	**21,415**	**(2,260)**	**19,155**
0	**0**	**0**			**CAPITAL SOURCES LESS PROGRAMME**	**0**	**0**	**0**

Sandwell & West Birmingham Hospitals NHS Trust

SUMMARY CAPITAL PROGRAMME 2014/15

Appendix 2a

CAPITAL PROGRAMME	PLAN April 2014 M01 £000's	PLAN May 2014 M02 £000's	PLAN June 2014 M03 £000's	PLAN July 2014 M04 £000's	PLAN August 2014 M05 £000's	PLAN September 2014 M06 £000's	PLAN October 2014 M07 £000's	PLAN November 2014 M08 £000's	PLAN December 2014 M09 £000's	PLAN January 2015 M10 £000's	PLAN February 2015 M11 £000's	PLAN March 2015 M12 £000's	PLAN TOTAL 2014/15 £000's
Year to date: April 2014													
CAPITAL FINANCING													
Original CRL excluding additional PDC	353	453	603	857	1,118	1,224	1,937	1,847	2,147	2,086	1,737	4,137	18,500
Original additional PDC	72	0	0	74	74	74	74	74	74	18	18	18	571
In year additional PDC												0	0
Other adjustments												0	0
Grants & Donations	7	7	7	7	7	7	7	7	7	7	7	7	84
TOTAL CAPITAL FINANCING	**432**	**460**	**610**	**938**	**1,199**	**1,305**	**2,018**	**1,928**	**2,228**	**2,111**	**1,763**	**4,163**	**19,155**
CAPITAL PROGRAMME													
Slippage and retentions	61	61	61	61	0	0	0	0	0	0	0	0	246
													0
Land Acquisition / Demolitions	250	250	250	250	250	250	250	250	250	250	250	250	3,000
Statutory Standards	0	35	65	100	85	180	400	410	110	65	50	0	1,500
Retained Estate Refurb - electrical infrastructure	0	0	100	0	50	50	0	100	700	300	300	400	2,000
Estates rationalisation / Energy Efficiency	0	0	0	100	100	100	200	0	0	0	0	0	500
Other Estates related schemes	0	0	20	20	20	0	0	0	0	0	0	0	59
													0
Medical Equipment	0	0	0	0	333	333	333	333	333	333	0	0	2,000
Maintenance Capex - Other	0	0	0	22	22	22	22	22	22	22	22	22	200
													0
Imaging	0	0	0	0	0	0	0	0	0	0	0	0	0
Catheter Lab	0	0	0	0	0	0	358	358	358	358	358	358	2,150
Bowel Cancer Screening	0	0	0	0	0	0	0	0	0	0	0	222	222
													0
IM&T - Year of Outpatients	0	0	0	63	83	63	65	65	65	198	198	198	1,000
IT and Telecomms - Phone exchange / data centre	0	0	0	0	0	0	83	83	83	417	417	417	1,500
PACS / VNA	0	0	0	207	207	207	207	207	207	52	52	52	1,399
VitalPAC (Better Hospitals element)	72	0	0	0	0	0	0	0	0	0	0	0	72
Other IM&T schemes	0	65	65	65	0	50	50	50	50	67	67	67	596
													0
Capitalised Salaries	42	42	42	42	42	42	42	42	42	42	42	42	500
Strategic Investments / Contingency	0	0	0	0	0	0	0	0	0	0	0	2,128	2,128
													0
Donated assets	7	7	7	7	7	7	7	7	7	7	7	7	84
TOTAL CAPITAL PROGRAMME	**432**	**460**	**610**	**938**	**1,199**	**1,305**	**2,018**	**1,928**	**2,228**	**2,111**	**1,763**	**4,163**	**19,155**
CAPITAL SOURCES LESS PROGRAMME	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Appendix 3

Capital Cash Management Plan 2014/15

TDA Plan £000		Current Plan £000
21,415	CAPITAL PROGRAMME	19,155
	Funding Sources:	
13,699	Depreciation	14,000
150	I & E Surplus	0
0	Net NBV of asset disposals and receipts	0
8,911	Unspent cash from previous financial years	4,500
84	Grants & Donations	84
571	PDC	571
0	Capital Loan Funding	0
23,415	TOTAL CAPITAL PROGRAMME FUNDING SOURCES	19,155
	Capital Resource Limit	
20,760	Initial CRL	18,500
	Anticipated adjustments:	
72	Better Hospitals Technology Fund (Vitalpac)	72
499	Better Hospitals Technology Fund (PACS / VNA)	499
21,331	PLANNED CRL	19,071

Sandwell and West Birmingham Hospitals NHS

NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – P01 April 2014
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance and Performance Management
AUTHOR:	Chris Archer, Associate Director of Finance - Corporate
DATE OF MEETING:	5 June 2014

EXECUTIVE SUMMARY:

Key messages:

- P01 deficit £249k being £168k adverse to plan. CIP delivery £412k being £193k adverse to plan.
- At this stage it is anticipated that the position will be recovered and the annual surplus target of £3.146m will be met. £14.1m CIP identified to date with £7.5 to be confirmed.
- Cash behind plan due to delayed receipt of income from Specialised Services [resolved] and Education commissioners [expected to be resolved] and higher than planned cash payments for non-pay revenue items reflecting settlement of year end trade payables.
- Slow start to capital programme.
- Continuity of service risk rating at 3 consistent with plan.
- Movements between expense headings are anticipated as detailed budget setting and identification of savings plans continue. Re-alignment of detailed budgets within group control totals expected to be largely resolved in May for P02 reporting. Residual issue being confirmation of balance of CIPs.

Key actions:

- Secure extant CIP scheme delivery & confirm route to resolution of residual balance.
- Continue with expedient measures to contain and control expenditure with emphasis on control of premium rate agency and medical staff premium rate working.
- Confirm prospective view of operational & financial risks and secure effective mitigations.
- Complete work to confirm detailed capital programmes for IM&T, Estates and medical equipment.
- Finalise devolved budget re-alignment.

Key numbers:

- In month deficit £249k being £168k adverse to plan.
- Forecast surplus £3.1m in line with financial plan.
- Capex £127k in month vs. £957k plan.
- Cash balance of £28.7m is £15.3m below plan at 30th April.

REPORT RECOMMENDATION:

The Trust Board is requested to RECEIVE the contents of the report and ENDORSE any actions taken to ensure that the Trust remains on target to achieve its planned financial position.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	x	Environmental		Communications & Media	
Business and market share		Legal & Policy	x	Patient Experience	
Clinical		Equality and Diversity		Workforce	x

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Good use of Resources
PREVIOUS CONSIDERATION:
Finance & Investment Committee and Performance Management Committee in May 2014

SWBTB (6/14) 082 (a)

Sandwell and West Birmingham Hospitals
NHS Trust

Financial Performance Report – April 2014 (month 1)

EXECUTIVE SUMMARY

- For the month of April 2014 (and hence financial year to date), **the Trust delivered a "bottom line" deficit of £249,000** compared to a planned deficit of £81,000 (as measured against the DoH performance target). The planned deficit reflected recognition of a phased approach to identification and delivery of savings plans and of investments. Actual savings delivery is assessed at £412k being £193k below plan.
- At this stage it is anticipated that the position will be recovered and the annual surplus target of £3.146m will be met.
- Group financial targets are consistent with those approved by the Board in the budget book, including savings delivery targets, and as adjusted for some disbursement of items held in reserves. **The re-alignment of directorate and granular budgets within those control totals is on-going and is expected to be largely progressed for P02** reporting together with SLA income.
- At month end there were 6,922 whole time equivalent (WTE) staff in post (excluding use of agency), 120 below the currently planned level (which may not reflect final savings or investment plans). After taking account of the impact of agency staff, **WTE's were 131 above plan**. Total **pay expenditure** for the month, including agency costs, **is £518,000 above the planned level.**
- **The month-end cash balance was £28.7m, £15.3m lower than revised cash plan**. This reflects timing differences. Expected cash from Specialised Services commissioners in April £3.2m [recovered in May] and Education commissioners £4.6m [expected recovery June] was not received and payments to suppliers were £7.4m higher reflecting the settlement of trade payables at the year end.
- Year to date spend on capital is £127,000 against plan £957k plan.

Financial Performance Indicators - Variances

Measure	Current Period	Year to Date	Thresholds: Green	Amber	Red
I&E Surplus Actual v Plan £000	(168)	(168)	>= Plan	>=99% of plan	<99% of plan
EBITDA Actual v Plan £000	(170)	(170)	>= Plan	>=99% of plan	<99% of plan
Pay Actual v Plan £000	(518)	(518)	<=Plan	<1% above plan	>1% above plan
Non Pay Actual v Plan £000	263	263	<= Plan	<= Plan	>1% above plan
WTEs Actual v Plan	(131)	(131)	<= Plan	<1% above plan	>1% above plan
Cash (incl Investments) Actual v Plan £000		(15,287)	>= Plan	>=95% of plan	<95% of plan

Note: positive variances are favourable, negative variances unfavourable

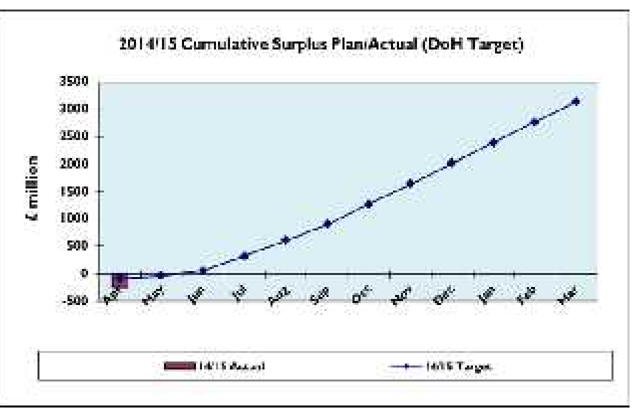
2014/15 Summary Income & Expenditure Performance at April 2014	Annual Plan £000's	CP Plan £000's	CP Actual £000's	CP Variance £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	Forecast Outturn £000's
Income from Activities	389,610	32,474	32,620	146	32,474	32,620	146	389,610
Other Income	41,012	3,436	3,375	(61)	3,436	3,375	(61)	41,012
Pay Expenses	(281,306)	(24,504)	(25,023)	(518)	(24,504)	(25,023)	(518)	(281,306)
Non-Pay Expenses	(124,760)	(9,703)	(9,440)	263	(9,703)	(9,440)	263	(124,760)
EBITDA	**24,556**	**1,703**	**1,533**	**(170)**	**1,703**	**1,533**	**(170)**	**24,556**
Depreciation	(13,988)	(1,166)	(1,166)	0	(1,166)	(1,166)	0	(13,988)
PDC Dividend	(5,027)	(419)	(419)	0	(419)	(419)	0	(5,027)
Net Interest Receivable / Payable	(2,244)	(187)	(185)	2	(187)	(185)	2	(2,244)
Other Finance Costs / P&L on sale of assets	(150)	(13)	(13)	0	(13)	(13)	0	(150)
SURPLUS/(DEFICIT) FOR DOH TARGET	**3,146**	**(81)**	**(249)**	**(168)**	**(81)**	**(249)**	**(168)**	**3,146**

Sandwell and West Birmingham Hospitals
NHS Trust

Financial Performance Report – April 2014

Overall Performance against Plan

The Trust delivered an actual deficit of £168,000 against a planned deficit of £81,000 in April. It is anticipated that this will be recovered in order to achieve the year end surplus target of £3.146m surplus.



Performance of Clinical Groups / Corporate Areas

•Medicine overspend of £460k: pay £332k, mainly ward staffing and non-pay mainly drugs offset to some extent by additional income for pass through drugs, net £128k.

•Surgery A overspend of £106k is all pay, mainly medical staff £83k premium rate working.

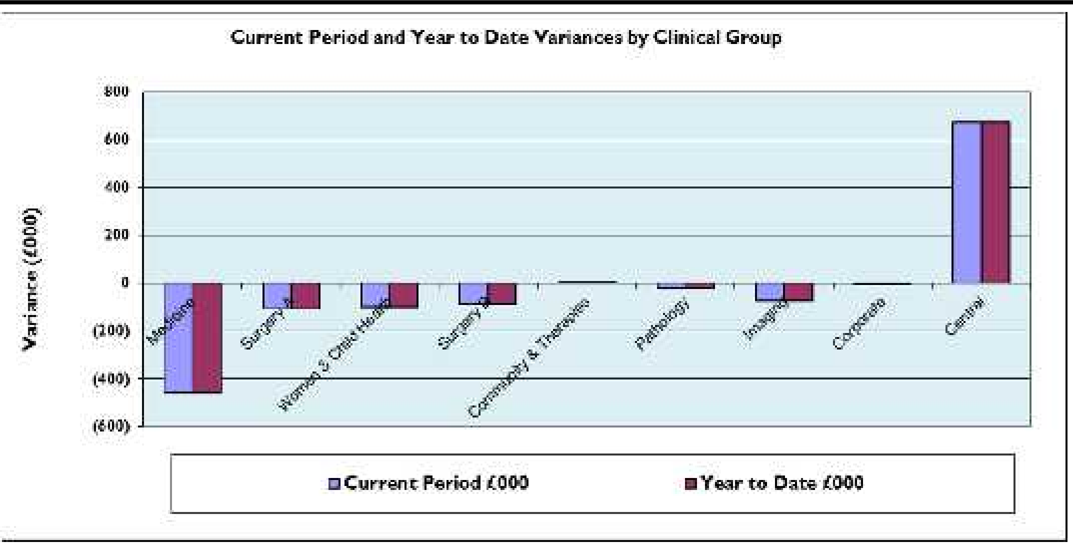
•Women & Child overspend £99k is mainly anticipated costs of antenatal pathways at other providers.

•Surgery B overspend £89k: nonpay overspend is largely offset by corresponding income improvement with medical staff pay overspending by £97k, mainly premium rate working.

•Imaging £73k overspend reflects lack of delivery of originally planned savings on pay.

Group Variances from Plan (Operating income and expenditure)	**Current Period £000**	**Year to Date £000**
Medicine	(460)	(460)
Surgery A	(106)	(106)
Women & Child Health	(99)	(99)
Surgery B	(89)	(89)
Community & Therapies	4	4
Pathology	(18)	(18)
Imaging	(73)	(73)
Corporate	(1)	(1)
Central	673	673

•The Central underspend of £673k reflects release of £436k funding for pay and non-pay inflationary pressures and £246k of planned release of investment reserves; movement of appropriate sums to Group positions will be undertaken for May.



NHS Trust

Financial Performance Report – April 2014

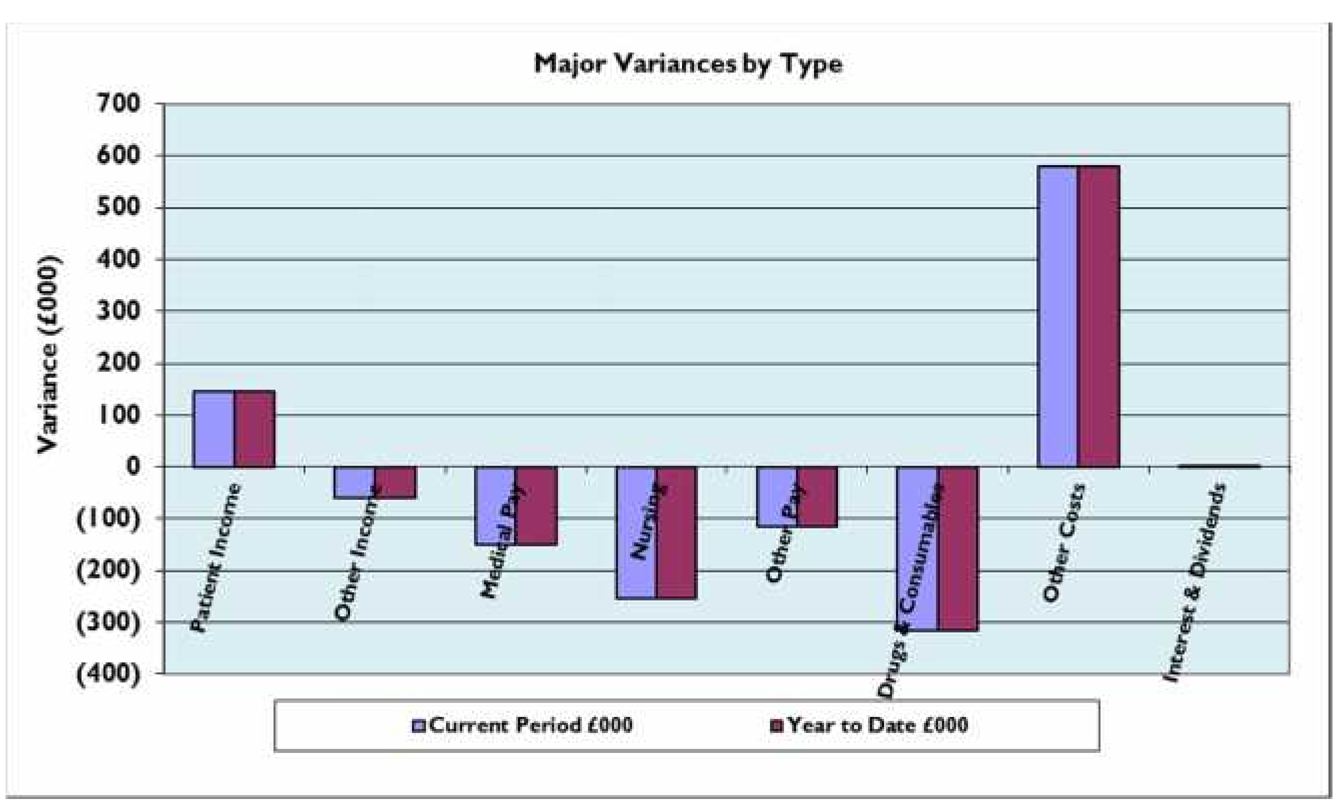
Overall headline adverse variance to plan £168k in April. There is still some movement of budgets between expenditure type headings to reflect savings and investment plans and distribution of inflation funding. Against current targets however:

Patient income over-performed reflecting pass through drugs arrangements.

Medical pay overspend is mainly premium rate working. Nursing and other pay is mainly in medicine wards and also facilities staff, with central release of pay inflation reserves.

Other costs reflects release of inflation and investment reserves.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
	(Adv) / Fav	(Adv) / Fav
Patient Income	146	146
Other Income	(61)	(61)
Medical Pay	(149)	(149)
Nursing	(254)	(254)
Other Pay	(115)	(115)
Drugs & Consumables	(316)	(316)
Other Costs	579	579
Interest & Dividends	2	2



Financial Performance Report – April 2014

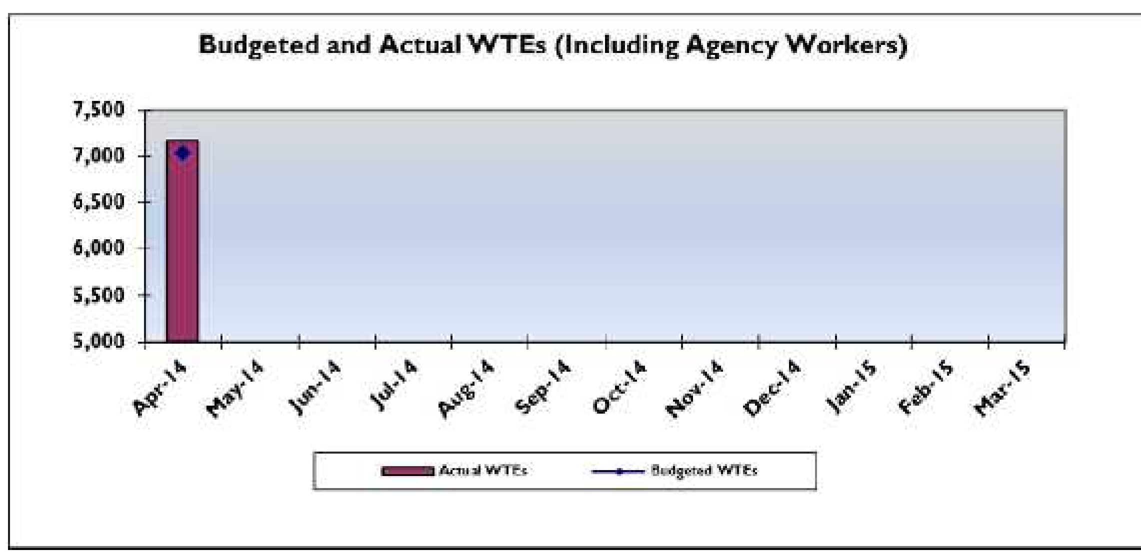
Paybill & Workforce

• There were 6,922 WTE in post in April plus an estimated 251 WTE of agency staffing across the month. In total this is 131 WTE above planned establishments, though these are subject to change as savings and investment plans are finalised.

•Total pay costs (including agency workers) at £25.0m are £518,000 above budget for the month.

•The overspends include medical staff £149,000, health care assistants and support staff £362,000 and qualified nursing and midwifery £254,000, with management and scientific and therapy staffing underspending and £183,000 of central pay inflation funding supporting the position.

•Gross expenditure for agency staff in April was £1,005,000 which shows no movement from the recent run rate.



Analysis of Total Pay Costs by Staff Group

	Year to Date to April 2014					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	6,424	6,187	0	386	6,573	(149)
Management	1,288	1,176	0	0	1,176	112
Administration & Estates	2,612	2,404	162	50	2,616	(4)
Healthcare Assistants & Support Staff	2,622	2,536	361	87	2,985	(362)
Nursing and Midwifery	7,557	7,015	365	430	7,810	(254)
Scientific, Therapeutic & Technical	3,657	3,457	0	51	3,509	149
Other Pay / Technical Adjustment	345	354	0	0	354	(9)
Total Pay Costs	24,504	23,129	889	1,005	25,023	(518)

Financial Performance Report – April 2014

Balance Sheet

- Cash balances at 30th April stood at £28.7m, a reduction of £13.2m over the month and £15.3m lower than plan.
- Of this, £3.3m is delay in income received Specialised Service £3.6m [recovered in May] Education funding £4.6m [expected recovery June] and £7.4m higher payments to suppliers. The level of payments in April is consistent (at £19m) April 2013 and relates to year end settlement of trade payables.
- The revised forecast cash flow for the next twelve months is shown overleaf.

STATEMENT OF FINANCIAL POSITION 2014/15

	Balance at 31st March 2014	Balance as at 30th April 2014	Forecast at 31st March 2015
	£000	£000	£000
Non Current Assets			
Property, Plant and Equipment	226,403	225,355	228,768
Intangible Assets	886	886	562
Trade and Other Receivables	1,011	1,295	700
Current Assets			
Inventories	3,272	3,213	3,600
Trade and Other Receivables	16,041	23,716	11,610
Cash and Cash Equivalents	41,944	28,656	24,388
Current Liabilities			
Trade and Other Payables	(53,867)	(48,168)	(43,546)
Provisions	(8,036)	(7,548)	(3,724)
Borrowings	(1,064)	(1,059)	(1,029)
DH Capital Loan	(2,000)	(2,000)	(1,000)
Non Current Liabilities			
Provisions	(2,562)	(2,562)	(2,522)
Borrowings	(27,915)	(27,921)	(27,884)
DH Capital Loan	(1,000)	(1,000)	
	193,113	**192,863**	**189,923**
Financed By			
Taxpayers Equity			
Public Dividend Capital	161,640	161,640	162,211
Retained Earnings reserve	(19,484)	(19,827)	(10,255)
Revaluation Reserve	41,899	41,992	28,909
Other Reserves	9,058	9,058	9,058
	193,113	**192,863**	**189,923**

Financial Performance Report – April 2014

CASH FLOW

12 MONTH ROLLING FORECAST AT April 2014

ACTUAL/FORECAST	Apr-14 £000s	May-14 £000s	Jun-14 £000s	Jul-14 £000s	Aug-14 £000s	Sep-14 £000s	Oct-14 £000s	Nov-14 £000s	Dec-14 £000s	Jan-15 £000s	Feb-15 £000s	Mar-15 £000s	Apr-15 £000s
Receipts													
SLAs: SWB CCG	21,328	21,165	21,165	21,165	21,165	21,165	21,165	21,165	21,165	21,165	21,165	21,165	21,165
Associates	6,176	6,417	6,417	6,417	6,417	6,417	6,417	6,417	6,417	6,417	6,417	6,417	6,417
Other NHS income	1,549	1,461	1,461	1,461	1,461	1,461	1,461	1,461	1,461	1,461	1,461	1,461	1,461
Specialised Service (LAT)	99	6,520	3,260	3,260	3,260	3,260	3,260	3,260	3,260	3,260	3,260	3,260	3,260
Education & Training		4,608		4,608			4,608			4,608			4,608
Public Dividend Capital												499	
Loans													
Other Receipts	1,651	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755
Total Receipts	30,803	41,926	34,058	38,666	34,058	34,058	38,666	34,058	34,058	38,666	34,058	34,557	38,666
Payments													
Payroll	13,895	14,539	14,512	14,025	14,007	14,007	13,616	13,616	13,616	13,613	13,613	13,613	13,613
Tax, NI and Pensions	9,567	9,693	9,675	9,350	9,338	9,338	9,077	9,077	9,077	9,076	9,076	9,076	9,076
Non Pay - NHS	4,186	1,905	1,905	2,034	2,034	2,034	2,148	2,148	2,148	2,148	2,148	2,148	2,148
Non Pay - Trade	12,144	7,308	7,309	7,826	7,825	7,825	8,282	8,281	8,281	8,282	8,281	8,281	8,282
Non Pay - Capital	2,895	2,466	2,899	2,957	1,707	1,315	1,963	1,963	2,836	2,775	2,656	1,660	2,775
PDC Dividend						2,610						2,610	
Repayment of Loans						1,000						1,000	
Interest		178	178	178	178	178	178	178	178	178	178	178	178
BTC Unitary Charge	428	375	375	375	375	375	375	375	375	375	375	375	375
Other Payments	975											4,810	
Total Payments	44,090	36,464	36,853	36,744	35,463	38,681	35,638	35,637	36,510	36,446	36,326	43,750	36,446
Cash Brought Forward	41,944	28,657	34,119	31,324	33,245	31,840	27,216	30,243	28,664	26,211	28,430	26,162	16,968
Net Receipts/(Payments)	(13,287)	5,462	(2,795)	1,922	(1,406)	(4,624)	3,027	(1,580)	(2,453)	2,220	(2,269)	(9,194)	2,220
Cash Carried Forward	28,657	34,119	31,324	33,245	31,840	27,216	30,243	28,664	26,211	28,430	26,162	16,968	19,188

Financial Performance Report – April 2014

Capital Expenditure

- Year to date capital expenditure is £127,000 vs. plan £957k.
- Detailed capital plans are being developed for estates, IM&T and capital equipment.

Continuity of Service Risk Rating

•The rating for April is 3 which is consistent with the planned position of 3 for the year.

	Financial Metric	2013/14 Full Year Accounts	Current Year to Date	Forecast Outturn
			Actual	Forecast
			(mc 03)	(mc 06)
		£000s	£000s	£000s
Continuity of Service Rating				
Liquidity Ratio (days)	Working Capital Balance	(6,982)	(6,403)	(13,301)
	Annual Operating Expenses	411,889	34,462	406,066
	Liquidity Ratio Days	(6.1)	(5.6)	(11.8)
	Liquidity Ratio Metric	**3**	**3**	**2**
Capital Servicing Capacity (times)	Revenue Available for Debt Service	27,071	1,533	24,556
	Annual Debt Service	10,082	697	10,368
	Capital Servicing Capacity (times)	**2.7**	**2.2**	**2.4**
	Capital Servicing Capacity metric	**4**	**3**	**3**
Continuity of Services Rating	**Continuity of Services Rating for Trust**	**4**	**3**	**3**

Savings Programme

- Progress on identification and delivery of savings is reported separately.
- Against the annual target of £20.6m, £14.1m of detailed plans have been identified with work on-going to determine a safe & appropriate route to delivery of the residual £7.5m.

Service Level Agreements

•SLA targets are held centrally for April and will be devolved for month 2. Income is assumed in line with the contract pending availability of activity and income detail, with the exception of pass through drugs which are over-performing at month 1. Specialised Services contract was signed in May and income will now flow.

Financial Performance Report – April 2014

Key risks

•**Specialised Commissioning** contract has now been signed and includes appropriate QUIPP and CQUIN schemes.

•Progress on CQUIN and other contract standards and other **commissioning risks** will be reported in due course.

• **Delivery of savings** is slower than the conservative plan for April. Finance and Investment Committee have received a separate detailed report on how the plan is to be delivered by the end of May.

•**Overspending on ward staffing.** Detailed work is going on to agree ward establishments consistent with safety requirements and enforce procedures and controls around deviation from agreed levels.

•**Premium rate waiting list work** is continuing in a number of specialties. More robust controls are being implemented along side work better to understand capacity constraints that mean demand is not consistently met.

•An emerging key cost pressure from **maternity payments to other providers** is anticipated in the April results. Plans to manage this pressure will be developed in order to mitigate the financial risk estimated at £1.0m for the year.

External Focus

•**The care bill has now become law** after receiving royal assent. Now the Care Act 2014, it was initially focused on reforming social care, but also includes clauses on the better care fund and was amended to widen the powers of Trust Special Administrators under the NHS unsustainable provider regime. This will allow TSAs to recommend changes in the provision of services across a local health economy and not just in the trust subject to the unsustainable providers regime.

•**The NHS trust sector ended 2013/14 with a net deficit of £241m**, according to NHS Trust Development Authority board papers. TDA chief executive David Flory said the financial position, still to be audited, was ‘a significant deterioration on the planned position’. NHS trust plans for 2014/15 showed the position was likely to deteriorate further with both a squeeze on income and pressure on expenditure, he said. Uncertainty over specialised commissioning contracts was a concern for the current financial year, while greater pooling of health and social care budgets was a major concern for 2015/16. Greater provider engagement was needed in the latter, he added. There was greater cause for optimism on securing sustainable services, particularly with the foundation trust pipeline, but he cautioned that a significant number of trusts had no clear trajectory for their future status.

•**The commissioning sector delivered an overall surplus of £790m against a plan of £534m in 2013/14**, according to NHS England. To deliver the final position, commissioners drew on £394m of accumulated surplus. The cumulative surplus fell from £1.184bn to £790m as a result. Clinical commissioning groups underspent by £97m in 2013/14, but there was a £347m overspend in direct commissioning. The direct commissioning overspend was driven largely by specialised commissioning activity growth and issues around budget baselines following the disaggregation of primary care trust budgets. The figures are based on submitted final accounts, which are currently undergoing external audit.

Financial Performance Report – April 2014

Recommendations

The Trust Board is asked to:

i. RECEIVE the contents of the report; and

ii. ENDORSE any actions taken to ensure that the Trust remains on target to achieve its planned financial position.

Tony Waite

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Monthly Corporate Performance Monitoring Report
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of Performance Management
DATE OF MEETING:	5 June 2014 (Report prepared 29 May 2014)

EXECUTIVE SUMMARY:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April 2014.

REPORT RECOMMENDATION:

The Trust Board is asked to consider the content of this report and its associated commentary.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		x

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	x	Environmental	x	Communications & Media	x
Business and market share	x	Legal & Policy	x	Patient Experience	x
Clinical	x	Equality and Diversity		Workforce	x

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Accessible and Responsive Care, High Quality Care and Good Use of Resources. National targets and Infection Control. Internal Control and Value for Money

PREVIOUS CONSIDERATION:

Operational Management Committee, Performance Management Committee, Clinical Leadership Executive and Quality & Safety Committee.

SWBTB (6/14) 083 (a)

Integrated Quality and Performance Report

April 2014

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Executive Overview

Patient Safety

(Areas of sub-optimal performance)

(What is driving current performance)

(What actions are being taken / planned to rectify current performance)

(When is an improvement in performance likely to be see, is there an improvement trajectory?)

(Horizon scanning - internal / external - likely to impact?)

Clinical Effectiveness

Mortality reviews within 42 days
Data issues meant that this target was not being actively managed in the month of February, the data issues were resolved and the 3x weekly monitoring has been raised to daily telephone calls to any consultants reviews who have not completed due reviews. This has brought the March Performance up to 83% currently and the overall quarterly performance to 80%.

Stroke admission within 4 hours
We've seen an improvement in percentage of patients receiving thrombolysis and an improvement in admission time to thrombolysis. Access targets for the stroke unit have fallen below target. This reflects challenges around maintaining discharge rates and flow through the unit. Thrombolysis in the scanner means patients get their treatment on time.

Maternity
we are currently responding to two CQC outlier alerts, one relating to neonatal readmissions for jaundice and feeding difficulties, and perinatal mortality. Both reports are complete but in draft form and details will be given verbally at the Trust Board.

Patient Experience

Patient Access

At A Glance

Infection Control

The number of cases of C Diff reported during the month was 3, compared with a trajectory of 4 for the period. There were no cases of MRSA Bacteraemia reported during the month. The incidence of MSSA and E. Coli, both expressed per 100,000 bed days are within TDA identified operational thresholds.

MRSA Screening for Elective and Non-Elective patients is reported as 88.4% and 94.3% respectively for the month.

Harm Free Care

Overall VTE Assessment compliance during April remains in excess of 95%, Group specific performance is between 94% (Women & Child Health) and 99% (Medicine).

All Groups met each of the 3 components reported for the WHO Surgical Checklist, with Trust performance for all elements exceeding operational thresholds.

There were 9 Open CAS Alerts reported and 1 Open Serious Incident Requiring Investigation during April.

Obstetrics

The overall Caesarean Section rate increased slightly to 26.2% (Elective 14.4%, Non-Elective 11.9%).

Admissions to Neonatal Intensive Care were 13.0% for the month of March, 10.7% during 2013 / 2014.

The Breast Feeding Initiation rate during 2013 / 2014 is 76.2%. The contractual target for 2014 / 2015 is set at 77.0%.

Mortality & Readmissions

The Trust's HSMR for the most recent 12-month cumulative period is 91.4, which remains beneath that of the SHA Peer (97.3). The City site HSMR remains beneath lower statistical confidence limits (77.4), with the Sandwell site HSMR (105.4), within statistical confidence limits for the most recent 12-month cumulative period.

Mortality rates for weekday and weekend, low risk diagnoses and CQC diagnosis groups are within or beneath statistical confidence limits.

During the most recent month for which complete data is available (February) the overall Trust performance for review of deaths within 42 days reduced to 75% (month trajectory of 80%). Overall performance is principally influenced by a review rate of 75% in Medicine.

Stroke Care & Cardiology

Stroke Care - performance against the range of stroke care related indicators is contained within the main body of this report. The main features to highlight are a reduction in the proportion of patients spending 90% or more of their stay on an Acute Stroke Unit (75.5%) and no improvement in the proportion of patients admitted to an Acute Stroke Unit within 4 hours (74.5%). Other reported Stroke Care metrics all met the identified operational thresholds.

Cancer Care

The Trust continues to meet, for month (March) and year to date all high level Cancer Treatment targets.

Exceptions at Group level were; Medicine (91.9%) and Surgery B (82.4%) both failed to meet the 93.0% operational threshold for the 2-week maximum cancer wait, and Medicine (83.3%) and Surgery B (80.0%) both narrowly failed to meet the 85.0% operational threshold for 62-day urgent GP referral to treatment.

Patient Experience - MSSA & Complaints

A total of 36 Mixed Sex Accommodation breaches were reported during the month of April comprising; Coronary Care Sandwell (5) and Priory 4 Sandwell (31). The Trust has recently introduced a new electronic tracking system to track gender bed allocation. In parallel processes on the stroke unit to ensure that patients are reviewed and stepped down from level 2 to level 1 much quicker in their pathway have been tightended. This transition has led to an unanticipated increase in mixed sex breaches as these patients remained in level 2 areas when they were level downgraded to level 1 care, on the Priory 4 Stroke unit. The Trust is reviewing bed flows and capacity on the stroke units to accommodate this and auditing the new procedures.

Patient Experience - Cancelled Operations

Cancelled Operatons - a breach of the 28-day late cancelled operation guarantee was reported for the month of April. The breach related to the specialty of Plastic Surgery. A Root Cause Analysis of the circumstances relating to the breach is underway.

Cancelled Operations - the proprtion of SitRep declared late cancellations during the month of April was 0.9%, a further reduction from previous months. Numerically late cancellations also reduced from 56 to 38 during the month, and were spread across a number of different specialties. No patients were subject to last minute cancellation on more than one occasion during the period.

Emergency Care

The Trust met the 4-hour ED wait target during the month of April with performance of 95.86%. The 95.0% operational threshold was met by each of the 3 constituent units.

Two of the ED Clinical Quality Indicators; Time to Initial Assessment and Unplanned Reattendance Rate are not being met. Both indicators feature within the Trust's Contractual Quality Requirements with its commissioners.

Fractured Neck of Femur - the proportion of patients who received an operation within 24 hours of admission remained beneath the 85.0% threshold, with performance during April reported as 64.3% (9 of 14 patients).

Referral To Treatment

Whilst the Trust continues to meet all high level RTT and Diagnostic Waits targets, there remain a number of specialties which are not meeting the required operational thresholds. One patient in General surgery is recorded as waiting in excess of 52 weeks on the Incomplete RTT Pathway at the end of the month (April). In terms of diagnostic waits, of 123 patients waiting for Cytoscopy, 27 (22%) are recorded as waiting in excess of 6-weeks.

Staff

PDR overall compliance as at the end of April stood at 94.61%, with range by Group 92 - 97%. Medical Appraisal compliance further improved to 98% at the end of the period.

Mandatory Training compliance remains at c.87%, with performance by Group ranging between 82% - 95%. A review of the current training programme is being undertaken.

Nurse Bank and Agency Use for the month of April remains high with almost 8000 shifts reported.

CQUIN

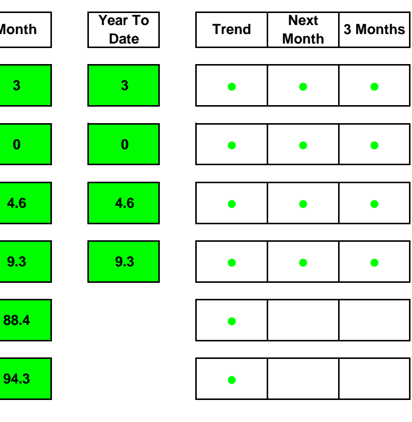
The Trust is contracted to deliver a total of 22 CQUIN schemes during 2014 / 2015. 9 schemes are nationally mandated, a further 10 have been agreed locally, with the remaining 4 identified by the West Midlands Specialised Commissioners. The collective financial value of the schemes is c.£8.3m.

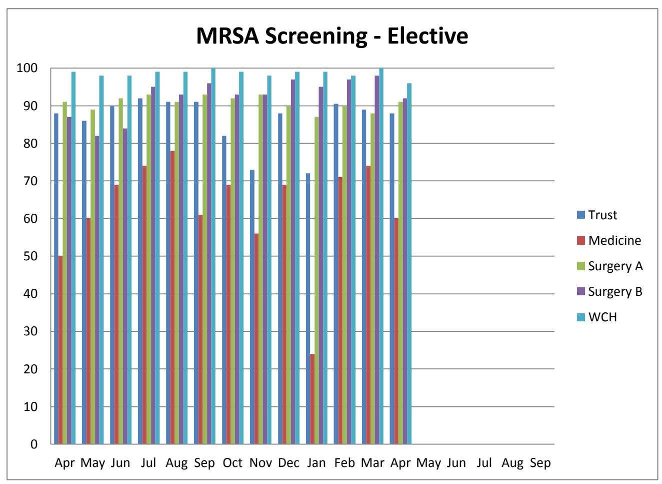
A significant number of the schemes require an initial baseline assessment during quarter 1, following which an improvement trajectory willl be agreed with commissioners.

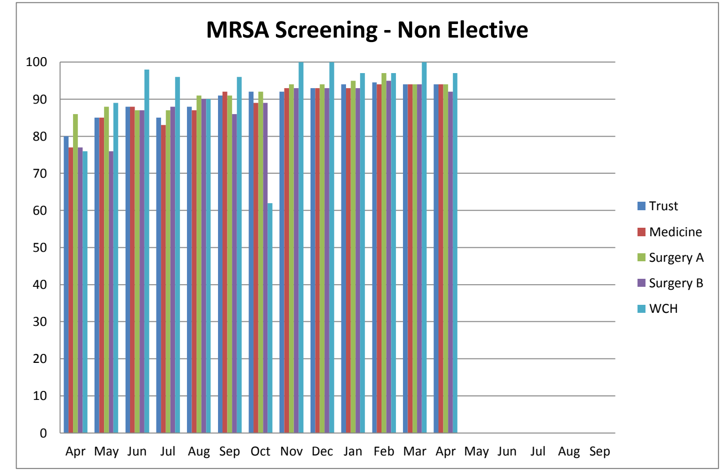
Of schemes with performance reported this month, Dementia screening failed to meet 90% in all 3 components (Find (97%), Assess (69%) and Refer (100%)). Contractual requirements are to deliver 90% in each component for each month during the quarter.

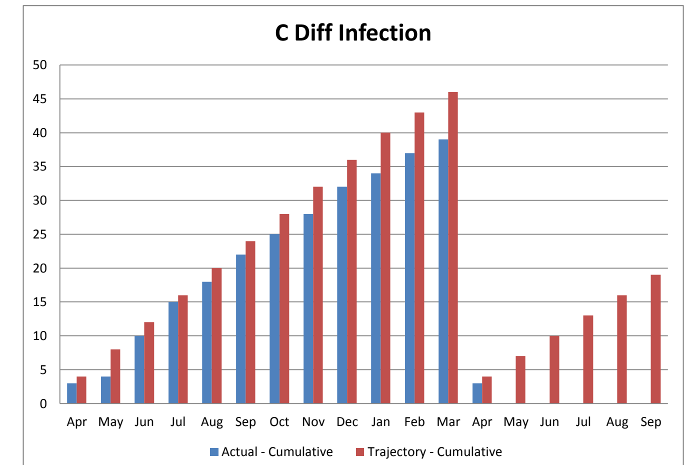
Patient Safety - Infection Control

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	Group A	Group B	Group W	Group P	Group I	Group C	Group CO	Month	Year To Date	Trend	Next Month	3 Months
4		●d●●	C. Difficile	37	4	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	1	2	0	0					3	3	●	●	●
4		●d●	MRSA Bacteraemia	0	0	● (red)	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	0	0	0	0					0	0	●	●	●
4			MSSA Bacteraemia (rate per 100,000 bed days)	<9.42	<9.42	●	●	●	●	●	●	● (red)	●	● (red)	●	●	●	●						Apr-14									4.6	4.6	●	●	●
4			E Coli Bacteraemia (rate per 100,000 bed days)	<94.9	<94.9	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14									9.3	9.3	●	●	●
3			MRSA Screening - Elective	80	80	●	●	●	●	●	●	● (red)	● (red)	●	●	●	●	●						Apr-14	60	90.6	92.2	96					88.4		●		
3			MRSA Screening - Non Elective	80	80	● (red)	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	94.4	94.4	92.4	97.2					94.3		●		



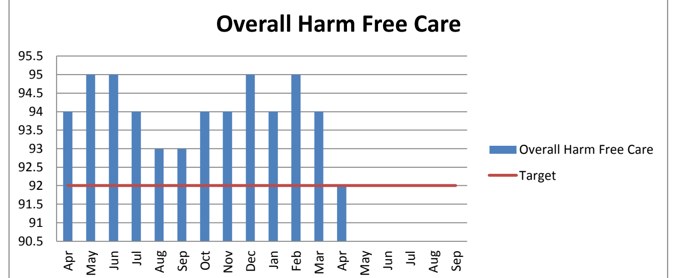


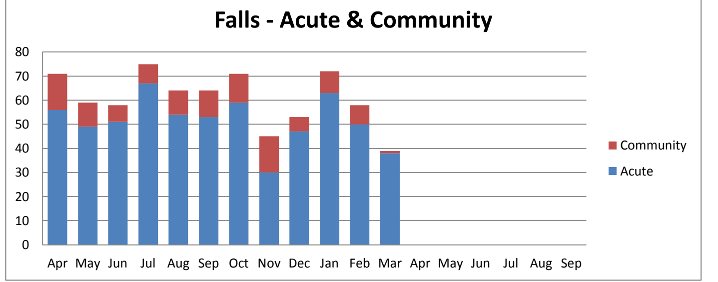


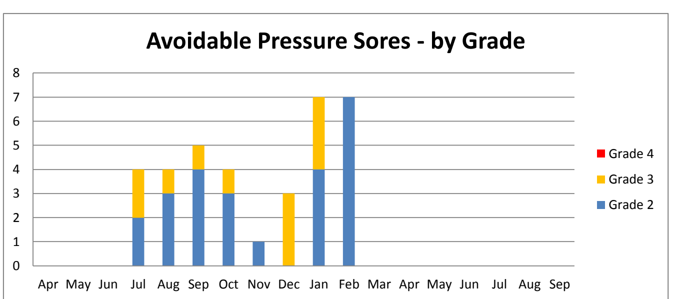


Patient Safety - Harm Free Care

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
8		•d	Patient Safety Thermometer - Overall Harm Free Care (%)	=>92	=>92	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14									92.2		●		
8			Falls	804	67	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	33	9	1	0		0	8		51	51	●		
9			Falls with a serious injury	0	0	3	3	4	●	●	1	6	2	6	2	1	2	1						Apr-14	1	0	0	0		0	0		1	1	●		
8			Grade 2,3 or 4 Pressure Ulcers (avoidable)	0	0				4	4	5	4	1	3	7	7	0							Mar-14	0	0	0	0			0		0	35	●		
3		•d•	Venous Thromboembolism (VTE) Assessments	95	95	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	99	98	98	94					98.3		●		
3			WHO Safer Surgery - Audit - 3 sections (% pts where all sections complete)	98	98	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	99.8	100	100	100					99.9		●		
3			WHO Safer Surgery - 3 sections and brief (% lists where complete)	95	95	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	99.6	100	99.3	100					99.2		●		
3			WHO Safer Surgery - Audit - 3 sections, brief and debrief (% lists where complete)	85	85	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	99.6	100	99.3	100					99.0		●		
9		•d•	Never Events	0	0	●	●	1	●	1	●	●	2	●	1	●	●	●						Apr-14	0	0	0	0	0	0	0		0	0	●		
9		•d	Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	0	0	0	0	0	0	0		0	0	●		
9		•d•	Serious Incidents	0	0	0	5	3	10	7	5	1	4	0	2	0	1							Mar-14									1	38	●		
9			Open Serious Incidents Requiring Investigation (SIRI)	0	0	5	9	8	11	8	6	9	6	7	6	1	4	1						Apr-14									1		●		
9		•d	Open Central Alert System (CAS) Alerts	0	0	5	5	3	6	6	8	7	6	9	9	8	11	9						Apr-14									9		●		

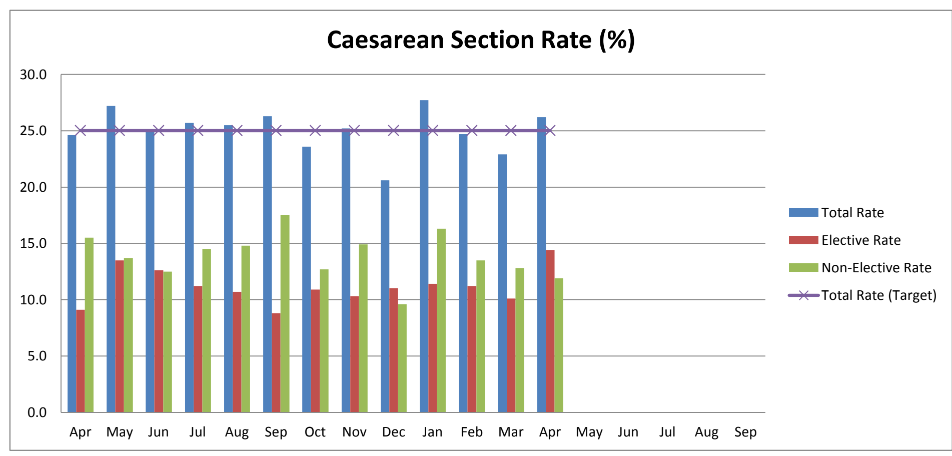


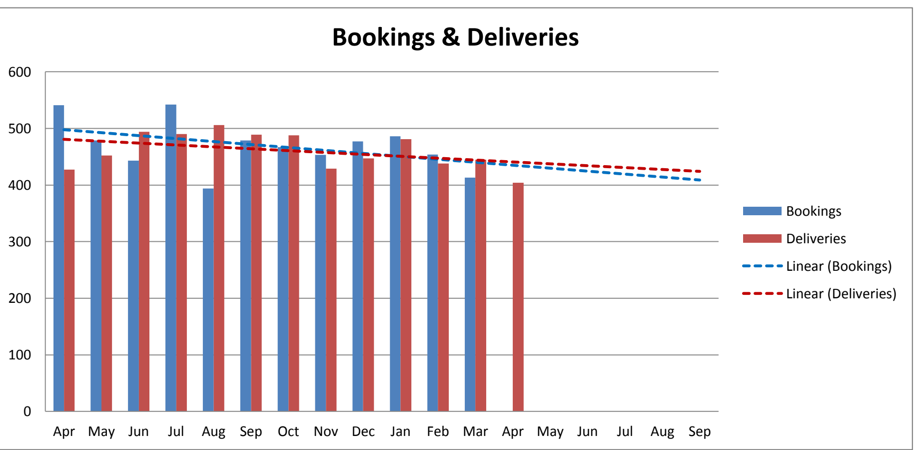




Patient Safety - Obstetrics

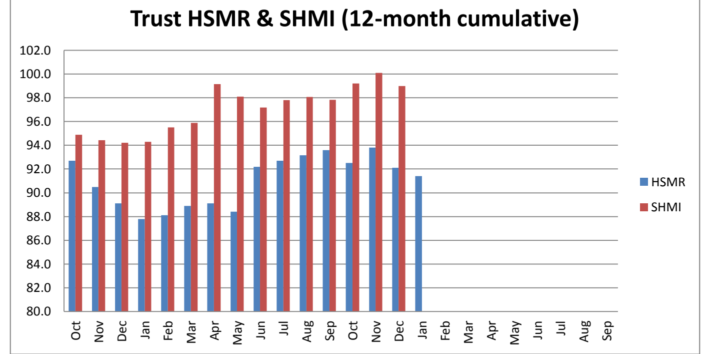
Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Month	Year To Date	Trend	Next Month	3 Months
3			Caesarean Section Rate - Total (%)	=<25.0	=<25.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	26.2	26.2	●		
3		●	Caesarean Section Rate - Elective (%)			9	14	13	11	11	13	11	10	11	12	11	10	14						Apr-14	14.4	14.4			
3		●	Caesarean Section Rate - Non Elective (%)			16	14	13	15	15	16	13	15	10	16	14	13	12						Apr-14	11.9	11.9			
2		•d	Maternal Deaths	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	0	0	●		
3			Post Partum Haemorrhage (>2000ml)	48	4	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	0	0	●		
3			Admissions to Neonatal Intensive Care (%)	=<10.0	=<10.0	●	●	●	●	●	●	●	●	●	●	●	●							Mar-14	13.9	10.7	●		
12			Adjusted Perinatal Mortality Rate (per 1000 babies)	<8.0	<8.0	●	●	●	●	●	●	●	●	●	●	●								Feb-14	6.8		●		
12			Early Booking Assessment (<12 + 6 weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●								Feb-14	145		●		
2			Breast Feeding Initiation (Quarterly) (%)	=>77.0	=>77.0			●			●			●			●							Mar-14	75.4	76.2	●		
2		●	Puerperal Sepsis and other puerperal infections (variation 1) (%)			4.2	7.0	2.3	5.1	4.3	2.4	1.9	1.9	3.4	1.3	2.3	0.7	2.0						Apr-14	2.0	2.0			
2		●	Puerperal Sepsis and other puerperal infections (variation 2) (%)			1.5	1.9	0.6	1.7	1.4	1.3	1.0	0.5	1.4	0.2	1.6	0.5	1.3						Apr-14	1.3	1.3			
2		●	Puerperal Sepsis and other puerperal infections (variation 3) (%)			0.5	0.9	0.0	0.9	0.6	0.9	0.2	0.2	0.5	0.2	0.2	0.0	0.5						Apr-14	0.5	0.5			

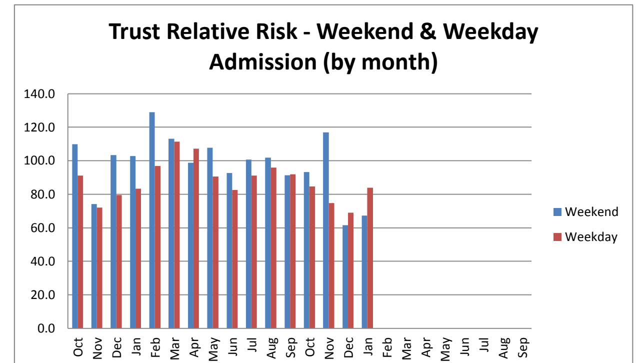


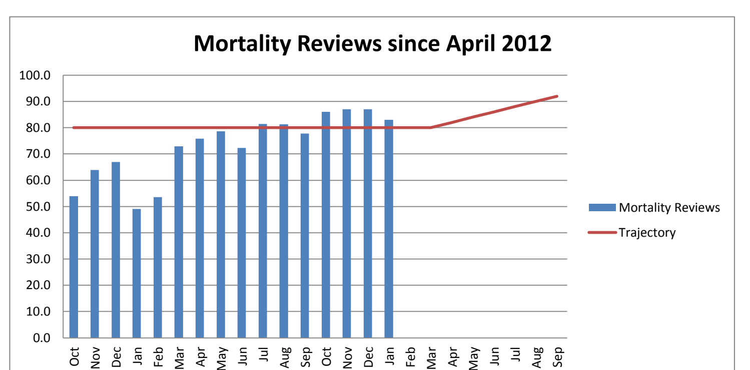


Clinical Effectiveness - Mortality & Readmissions

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	Group A	Group B	Group W	Group P	Group I	Group C	Group CO	Month	Year To Date	Trend	Next Month	3 Months
5		● C ●	Hospital Standardised Mortality Rate - Overall (12-month cumulative)	Below Upper CI	Below Upper CI	89	88	92	93	93	94	93	94	92	91									Jan-14	100	83	48	86						91.4	●		
5		● C ●	Hospital Standardised Mortality Rate - Weekday (12-month cumulative)	Below Upper CI	Below Upper CI	89	91	89	90	90	91	88	89	88	84									Jan-14	88	89	26	77						83.9	●		
5		● C ●	Hospital Standardised Mortality Rate - Weekend (12-month cumulative)	Below Upper CI	Below Upper CI	98	99	101	102	104	102	98	102	98	67									Jan-14	94	106	71	89						67.3	●		
6		● C ●	Summary Hospital-level Mortality Index (12-month cumulative)	Below Upper CI	Below Upper CI	99	98	97	98	98	98	99	100	99										Dec-13	100	83	48	86						99.0	●		
5		● C ●	Deaths in Low Risk Diagnosis Groups	Below Upper CI	Below Upper CI	●	●	●	●	●	●	●	●	●	●									Jan-14									58.9		●		
3			Mortality Reviews within 42 working days	100	=>80.0	●	●	●	●	●	●	●	●	●	●	●								Feb-14	75	87	100	0					75		●		
5		● C ●	Emergency Readmissions (within 30 days) - Overall (%) (12-month cumulative)			9.1			8.9			8.9												Jan - Dec 13									8.9				
5		●	Emergency Readmissions (within 30 days) - Following Initial Elective Admission (%) (12-month cumulative)			4.1			4.2			4.1												Jan - Dec 13									4.1				
5		●	Emergency Readmissions (within 30 days) - Following Initial Non Elective Admission (%) (12-month cumulative)	=<10.9	=<10.9	13.7			13.3			13.4												Jan - Dec 13									13.4		●		



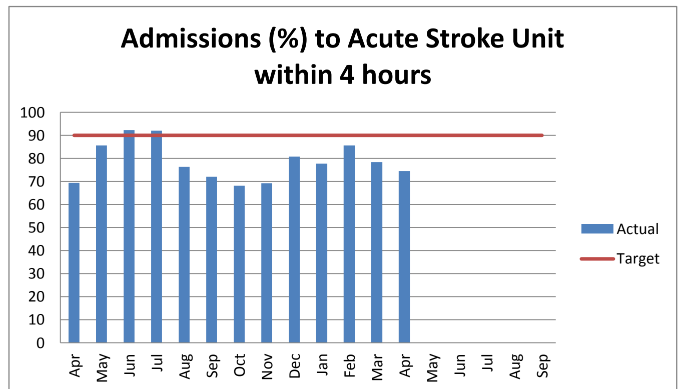


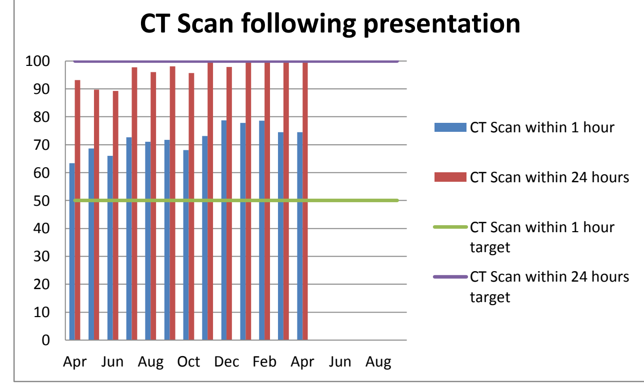


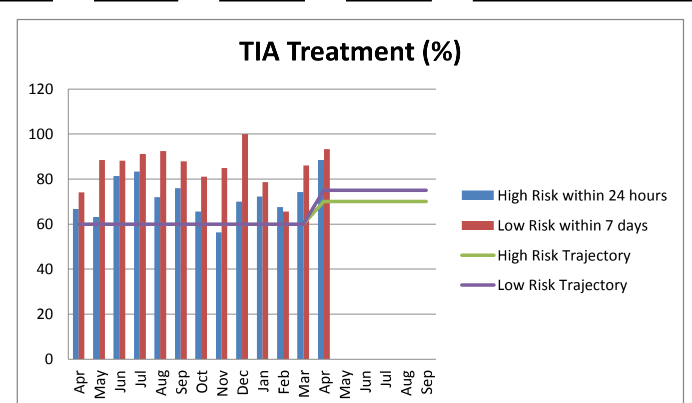
Clinical Effectiveness - Stroke Care & Cardiology

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Month	Year To Date	Trend	Next Month	3 Months
3			Pts spending >90% stay on Acute Stroke Unit (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	75.5	75.5	●		
3			Pts admitted to Acute Stroke Unit within 4 hrs (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	74.5	74.5	●		
3		●	Pts receiving CT Scan within 1 hr of presentation (%)	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	74.5	74.5	●		
3			Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	100.0	100.0	●		
3			Stroke Admission to Thrombolysis Time (% within 60 mins)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	100.0	100.0	●		
3			Stroke Admissions - Swallowing assessments (<24h) (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	100.0	100.0	●		
3			TIA (High Risk) Treatment <24 Hours from initial presentation (%)	=>70.0	=>70.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	88.5	88.5	●		
3			TIA (Low Risk) Treatment <7 days from initial presentation (%)	=>75.0	=>75.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	93.3	93.3	●		
9			Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●	●	●	●							Mar-14	58 (C) & 90 S)		●		
9			Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●	●	●	●							Mar-14	60 (C) & 100(S)		●		
9			Rapid Access Chest Pain - seen within 14 days (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●							Mar-14	92.0	95.7	●		

Previous Months Trend (since April 2013)

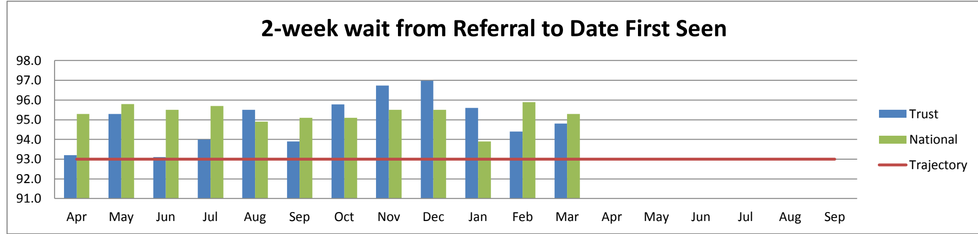


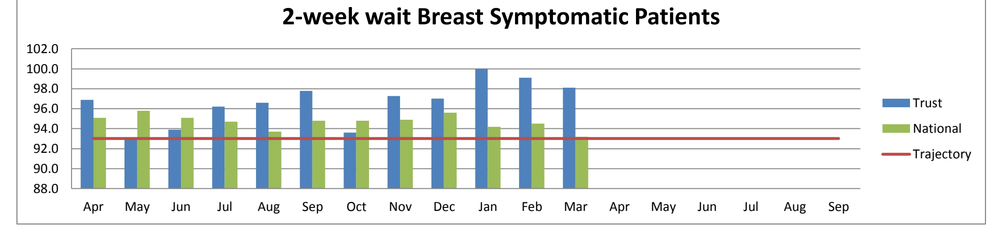


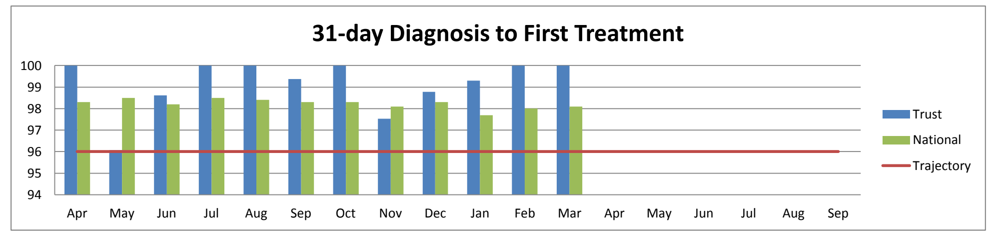


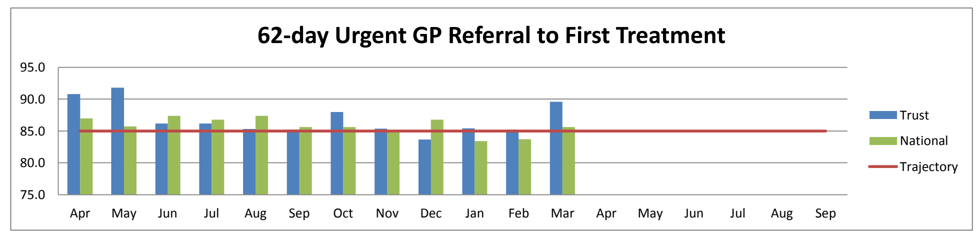
Clinical Effectiveness - Cancer Care

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	Group A	Group B	Group W	Group P	Group I	Group C	Group CO	Month	Year To Date	Trend	Next Month	3 Months
1	○	●e●	2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●							Mar-14	91.9	97.1	82.4	98.5					94.8	95.0	●		
1	○	●e●	2 weeks (Breast Symptomatic)	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●							Mar-14		98.1							98.1	96.7	●		
1	○	●e●●	31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●	●							Mar-14	100	100	100	100					100.0	99.2	●		
1	○	●e●	31 Day (second/subsequent treatment - surgery)	=>94.0	=>94.0	●	●	●	●	●	●	●	●	●	●	●	●							Mar-14									100.0	98.6	●		
1	○	●e●	31 Day (second/subsequent treatment - drug)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●							Mar-14									100	100	●		
1	○	●e●	31 Day (second/subsequent treat - radiotherapy)	=>94.0	=>94.0	n/a	n/a	n/a	n/a	n/a	n/a	n/a	●	n/a	n/a	n/a	●							Mar-14									100	100	●		
1	○	●e●●	62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●							Mar-14	83.3	88.2	80.0	100					89.6	87.0	●		
1	○	●e●●	62 Day (referral to treat from screening)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●							Mar-14		100							100	98.2	●		
1	○		62 Day (referral to treat from hosp specialist)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●							Mar-14	100	100		100					100	92.4	●		









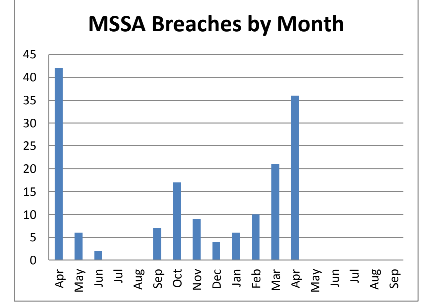
Patient Experience - FFT, Mixed Sex Accommodation & Complaints

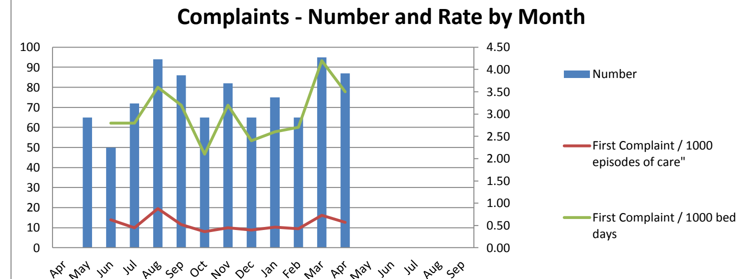
Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month
8		•b•	FFT Response Rate - Inpatients	=>30.0	=>30.0
8		•a•	FFT Score - Inpatients	=>60.0	=>60.0
8		•b•	FFT Response Rate Emergency Department	=>20.0	=>20.0
8		•a•	FFT Score - Emergency Department	=>46.0	=>46.0
13		•a	Mixed Sex Accommodation Breaches	0	0
9		•	No. of Complaints Received (formal and link)		
9			No. of Active Complaints in the System (formal and link)		
9		•a	No. of First Formal Complaints received / 1000 bed days		
9			No. of First Formal Complaints received / 1000 episodes of care		
9			No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	100	100
9			No. of responses which have exceeded their original agreed response date (% of total active complaints)	0	0
9			No. of responses sent out		
9			Oldest' complaint currently in system (days)		
14		•e•	Access to healthcare for people with Learning Disability (full compliance)	Yes	Yes

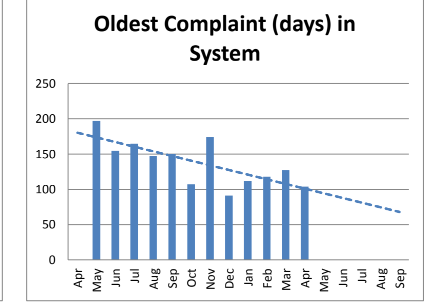
Previous Months Trend (since April 2013)

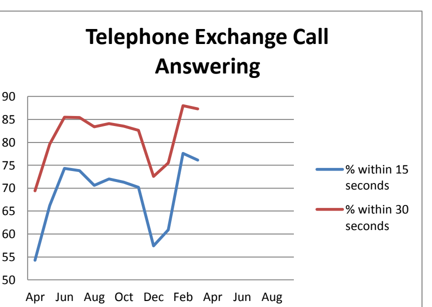
Indicator	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S
FFT Response Rate - Inpatients	31	40	30	35	31	19	29	31	29	31	34	36	36					
FFT Score - Inpatients	66	66	67	68	37	72	71	70	73	71	75	73	74					
FFT Response Rate Emergency Department	2.2	3.7	9.6	5	5.3	12	21	17	15	15	16	15	15					
FFT Score - Emergency Department	55	49	50	49	50	51	46	47	44	47	48	48	47					
Mixed Sex Accommodation Breaches	42	6	2	0.5	0.4	7	17	9	4	6	10	21	36					
No. of Complaints Received (formal and link)	63	65	50	72	94	56	65	52	65	75	65	95	87					
No. of Active Complaints in the System (formal and link)		302	336	272	254	238	201	201	190	188	188	210	194					
No. of First Formal Complaints received / 1000 bed days			2.8	2.8	3.6	3.2	2.1	3.2	2.4	2.6	2.7	4.2	3.5					
No. of First Formal Complaints received / 1000 episodes of care			0.6	0.5	0.9	0.5	0.4	0.5	0.4	0.5	0.4	0.7	0.6					
No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)		97	78	94	97	75	97	99	98	97	95	99	100					
No. of responses which have exceeded their original agreed response date (% of total active complaints)		28	32	36	25	22	33	29	20	35	53	41	33					
No. of responses sent out		17	5	128	73	78	109	59	79	81	58	67	117					
Oldest' complaint currently in system (days)		197	155	165	147	150	107	174	91	112	118	127	104					
Access to healthcare for people with Learning Disability (full compliance)	●	●	●	●	●	●	●	●	●	●	●	●	●					

Indicator	Data Period	Group M	Group A	Group B	Group W	Group P	Group I	Group C	Group CO	Month	Year To Date	Trend	Next Month	3 Months
FFT Response Rate - Inpatients	Apr-14									36.0		●		
FFT Score - Inpatients	Apr-14									74.0		●		
FFT Response Rate Emergency Department	Apr-14	15								14.8		●		
FFT Score - Emergency Department	Apr-14	47								47.0		●		
Mixed Sex Accommodation Breaches	Apr-14	36	0	0	0		0	0		36	36	●		
No. of Complaints Received (formal and link)	Apr-14									87	87			
No. of Active Complaints in the System (formal and link)	Apr-14									194				
No. of First Formal Complaints received / 1000 bed days	Apr-14									3.5	3.5			
No. of First Formal Complaints received / 1000 episodes of care	Apr-14									0.57	0.57			
No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	Apr-14									100		●		
No. of responses which have exceeded their original agreed response date (% of total active complaints)	Apr-14									33		●		
No. of responses sent out	Apr-14									117				
Oldest' complaint currently in system (days)	Apr-14									104				
Access to healthcare for people with Learning Disability (full compliance)	Apr-14	Y	Y	Y	Y	Y	Y	Y	Y	Yes		●		

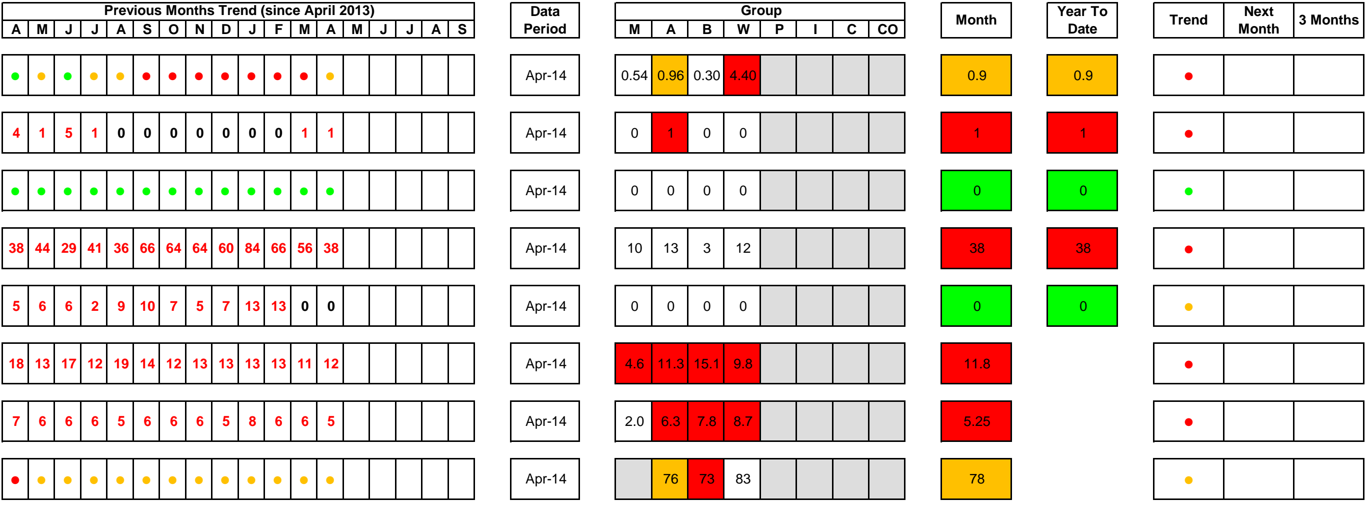




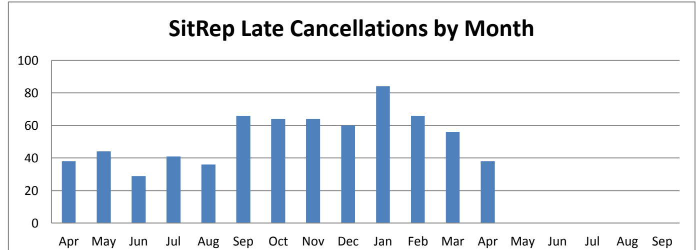


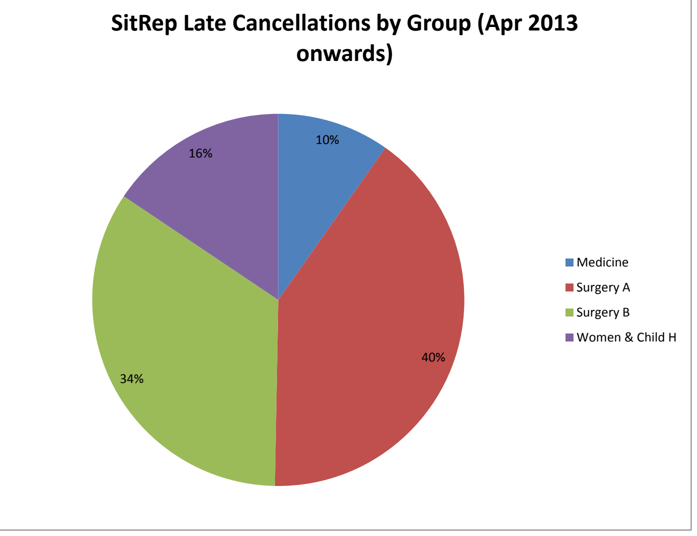


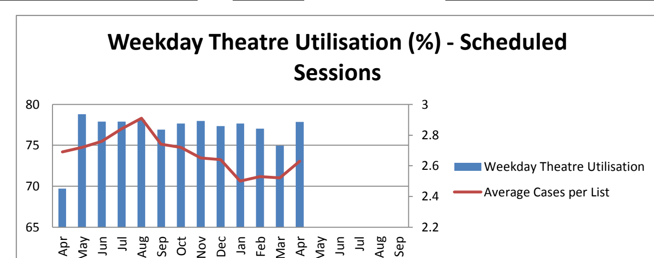
Patient Experience - Cancelled Operations

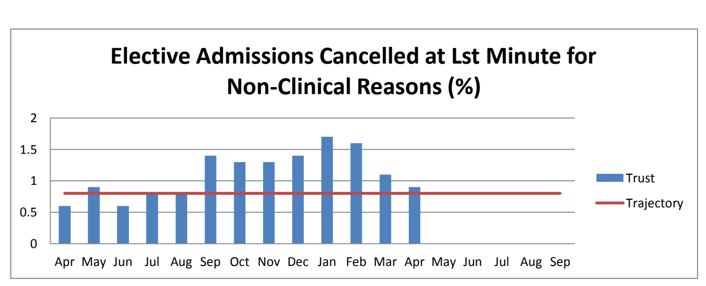


Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	Group A	Group B	Group W	Group P	Group I	Group C	Group CO	Month	Year To Date	Trend	Next Month	3 Months
2		●	Elective Admissions Cancelled at last minute for non-clinical reasons (%)	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	0.54	0.96	0.30	4.40					0.9	0.9	●		
2		•e•	28 day breaches	0	0	4	1	5	1	0	0	0	0	0	0	0	1	1						Apr-14	0	1	0	0					1	1	●		
2		•e	No. of second or subsequent urgent operations cancelled	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	0	0	0	0					0	0	●		
2			Sitrep Declared Late Cancellations	320	27	38	44	29	41	36	66	64	64	60	84	66	56	38						Apr-14	10	13	3	12					38	38	●		
3			Sitrep Declared Late Cancellations (Pts. >1 occasion)	0	0	5	6	6	2	9	10	7	5	7	13	13	0	0						Apr-14	0	0	0	0					0	0	●		
3			Multiple Cancellations experienced by same patient (all cancellations) (%)	0	0	18	13	17	12	19	14	12	13	13	13	13	11	12						Apr-14	4.6	11.3	15.1	9.8					11.8		●		
3			All Cancellations, with 7 or less days notice (expressed as % overall elective activity)	3.1	3.1	7	6	6	6	5	6	6	6	5	8	6	6	5						Apr-14	2.0	6.3	7.8	8.7					5.25		●		
3			Weekday Theatre Utilisation (as % of scheduled)	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14		76	73	83					78		●		



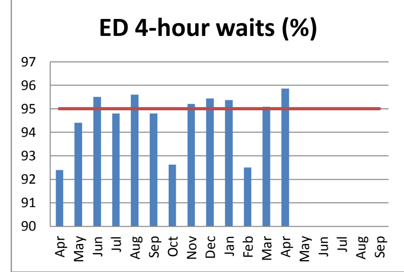


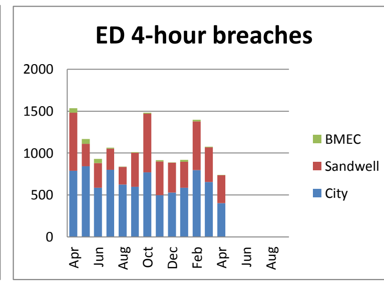


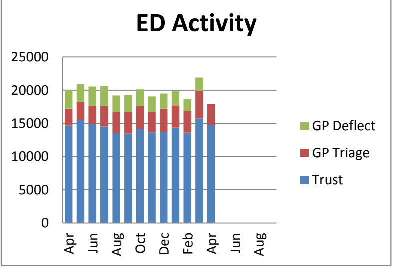


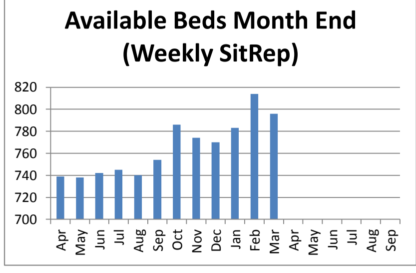
Access To Emergency Care & Patient Flow

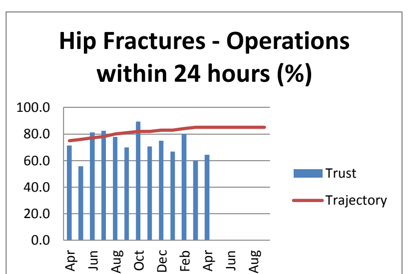
Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Unit S	Unit C	Unit B	Month	Year To Date	Trend	Next Month	3 Months
2		● e ● ●	Emergency Care 4-hour waits (%)	=>95.0	=>95.0	red	red	green	red	green	red	red	green	green	green	red	green	green						Apr-14	95.6	95.2	99.7	95.86	95.86	amber		
2		● e	Emergency Care Trolley Waits >12 hours	0	0	1	green	green	green	green	green	green	green	green	green	green	green	green						Apr-14	0	0	0	0	0	green		
3			Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins	red	red	red	red	red	red	red	red	red	red	red	red	red						Apr-14	17	21	14	19	19	red		
3			Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins	green	green	green	green	green	green	green	green	green	green	green	green	green						Apr-14	51	52	20	46	46	green		
3			Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0	red	red	red	red	red	red	red	red	red	red	red	red	red						Apr-14	7.07	5.09	2.65	5.58	5.58	red		
3			Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0	green	green	green	green	green	green	green	green	green	green	green	green	green						Apr-14	3.27	4.00	1.38	3.33	3.33	green		
11			WMAS - Handovers (emergency conveyances) 30 - 60 mins (number)	0	0	red	red	red	red	red	red	red	red	red	red	red	red	red						Apr-14	49	67		116	116	red		
11			WMAS - Handovers (emergency conveyances) >60 mins (number)	0	0	red	red	red	red	red	red	red	red	red	red	red	red	red						Apr-14	8	7		15	15	red		
11			WMAS - Turnaround (emergency conveyance) Delays 30 - 60 mins	0	0	red	red	red	red	red	red	red	red	red	red	red	red	red						Apr-14	500	767		1267	1267	red		
11			WMAS - Turnaround (emergency conveyance) Delays >60 mins	0	0	red	red	red	red	red	red	red	red	red	red	red	red	red						Apr-14	9	16		25	25	red		
11		●	WMAS - Turnaround Delays > 60 mins (% all journeys)	=<0.02	=<0.02	red	red	red	red	red	red	red	red	red	red	red	red	red						Apr-14	0.5	0.7		0.62		red		
2			Delayed Transfers of Care (Acute) (%)	=<3.5	=<3.5	green	green	green	green	amber	amber	amber	green	green	green	green	green	green						Apr-14				3.2	3.2	green		
2			Delayed Transfers of Care (Acute) (No.)	<10 per site	<10 per site													green						Apr-14	6	5		11	11	green		
2			Patient Bed Moves (11pm - 6am) (No.)																													
3			Hip Fractures - Operation < 24 hours of admission (%)	=>85.0	=>85.0	red	red	amber	red	green	green	green	red	red	red	red	red	red						Apr-14				64.3	64.3	red		





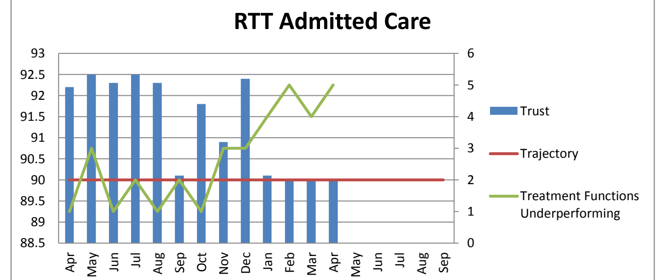


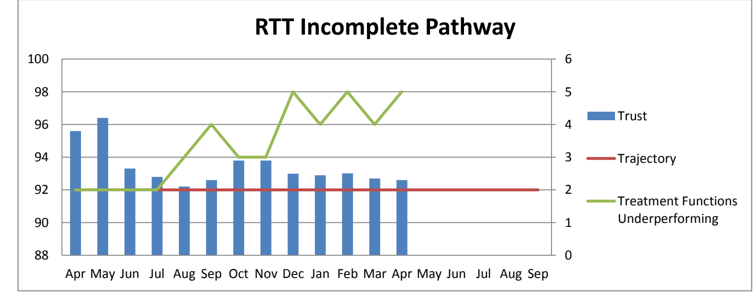


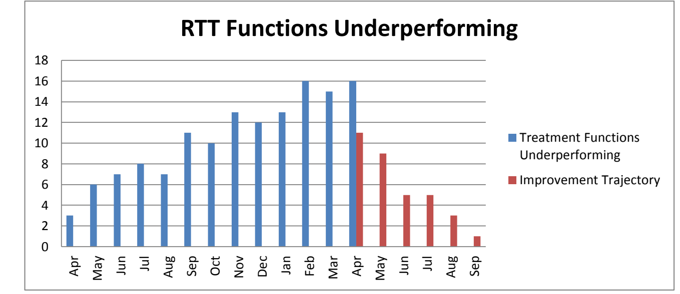


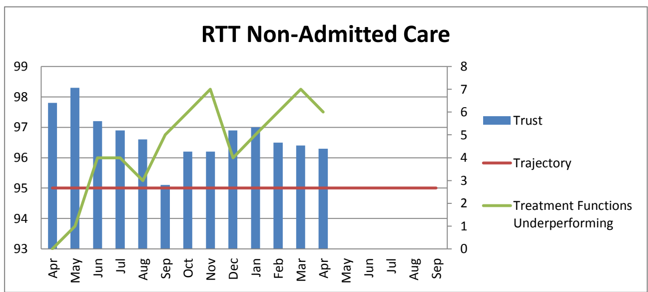
Referral To Treatment

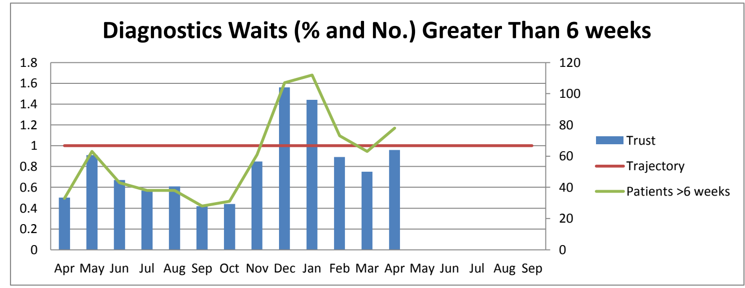
Data Source	Data Quality	PAF	Indicator	Trajectory		Previous Months Trend (since April 2013)																		Data Period	Group								Month	Year To Date	Trend	Next Month	3 Months
				Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		M	A	B	W	P	I	C	CO					
2		●e●●	RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	95.0	79.8	90.6	93.1					90.02		●		
2		●e●●	RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	92.8	94.5	98.4	95.7					96.31		●		
2		●e●●	RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	92.2	89.1	94.2	97.9					92.67		●		
2		●e	Patients Waiting >52 weeks	0	0	8	28	50	57	29	20	66	36	12	3	1	1	1						Apr-14	0	1	0	0					1		●		
2			Treatment Functions Underperforming	0	0	3	6	7	8	7	11	10	13	12	13	16	15	16						Apr-14	6	7	3	0					16		●		
2		●e●	Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	1.31	10.3	0.93	0.00		0.25			0.96		●		

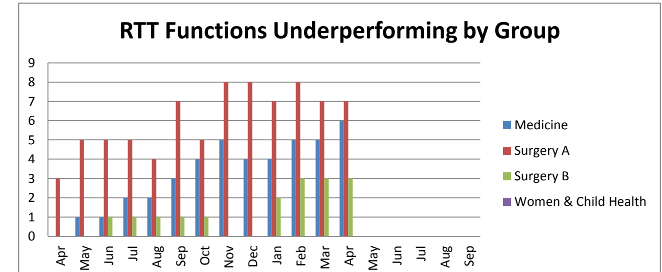












Data Completeness

Data Source	Data Quality	PAF	Indicator	Trajectory		Previous Months Trend (since April 2013)																		Data Period	Group								Month	Year To Date	Trend	Next Month	3 Months
				Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		M	A	B	W	P	I	C	CO					
14		●	Data Completeness Community Services	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14								>50	>50		●		
2		●	Percentage SUS Records for AE with valid entries in mandatory fields	=>99.0	=>99.0																																
2		●	Percentage SUS Records for IP care with valid entries in mandatory fields	=>99.0	=>99.0																																
2		●	Percentage SUS Records for OP care with valid entries in mandatory fields	=>99.0	=>99.0																																
2			Completion of Valid NHS Number Field in acute (inpatient) data set submissions to SUS	=>99.0	=>99.0	99.3	99.3	99.2	99.2	99.1	99.1	99.1	98.9	99.2	98.9	98.9	98.7	98.7						Apr-14									98.7	98.7	●		
2			Completion of Valid NHS Number Field in acute (outpatient) data set submissions to SUS	=>99.0	=>99.0	99.7	99.8	99.7	99.7	99.7	99.7	99.7	99.7	99.7	99.7	99.6	99.5	99.5						Apr-14									99.5	99.5	●		
2			Completion of Valid NHS Number Field in A&E data set submissions to SUS	=>95.0	=>95.0	97.8	97.3	97.4	97.2	97.4	97.3	97.5	97.2	97.1	97.6	96.8	95.9	96.3						Apr-14									96.3	96.3	●		
2			Ethnicity Coding - percentage of patients with recorded response	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14									92.57	92.57	●		
2		●b●	Data Quality of Trust Returns to the HSCIC																																		
2			Maternity - Percentage of invalid fields completed in SUS submission	=<15.0	=<15.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14									6.78	6.78	●		

Staff

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
7		• b	WTE - Actual versus Plan			312	456	465	458	511	610	643	626	572	541	567								Feb-14	163	76	37	34	33	28	34	162	567	567			
3		• b •	PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	93	92	97	94	97	97	96	96		94.61	●		
7		• b	Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	100	100	87	100	100	97	100	100		98.0	●		
3		• b	Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	3.8	5.4	2.5	4.2	3.6	4.4	4.5	3.9	4.11	4.30	●		
3			Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	82	86	86	86	95	92	91	90		86.94	●		
3		•	Mandatory Training - Health & Safety (% staff)	=>75.0	=>75.0											●	●	●						Apr-14	96	98	97	97	99	98	100	100		98.21	●		
7		• b •	Staff Turnover (rolling 12 months) (%)	2.7 - 18.8	2.7 - 18.8	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14									11.83	11.83	●		
7			New Investigations in Month			4	5	8	9	1	4	3	1	4	2	4	5	1						Apr-14	1	0	0	0	0	0	0	0	1				
7			Vacancy Time to Fill (weeks)			15	19	18	18	18	18	18	17	18	20	18	19	18						Apr-14									18	18			
7		•	Professional Registration Lapses	0	0	3	0	0	1	0	4	7	0	0	0	0	0	**0**						Apr-14									0	0	●		
7			Qualified Nursing Variance (FIMS) (FTE)			26	108	138	143	181	236	177	199	210	163	162								Feb-14									162	162			
10			Nurse Bank Fill Rate			72	77	75	77	78	76	75	76	71	73	75	76	76						Apr-14									76.1	76.1			
10			Nurse Bank Use	46980	3915	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	2769	768	211	503	0	19	273	130	4673	4673	●		
10			Nurse Agency Use	3830	319	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	2177	483	73	77	0	132	269	9	3220	3220	●		
15			Your Voice - Response Rate																					Feb-14	8	13	18	11	36	19	18	26					
15			Your Voice - Overall Score																					Feb-14	3.7	3.6	3.7	3.8	3.6	3.7	3.8	3.6					

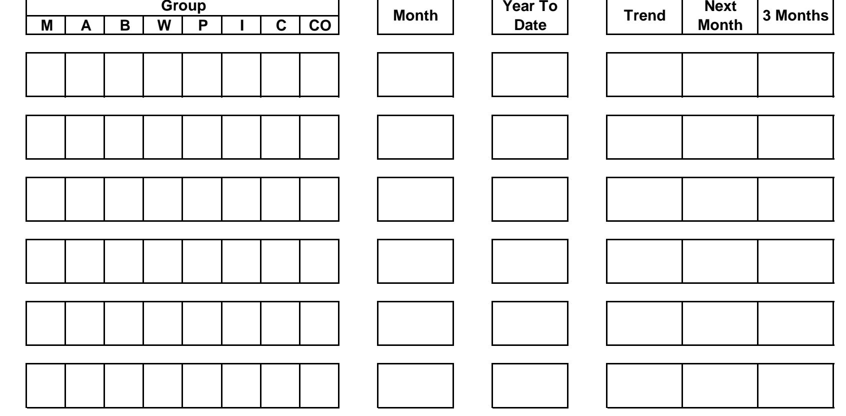
Previous Months Trend (since April 2013); Group columns: M, A, B, W, P, I, C, CO.

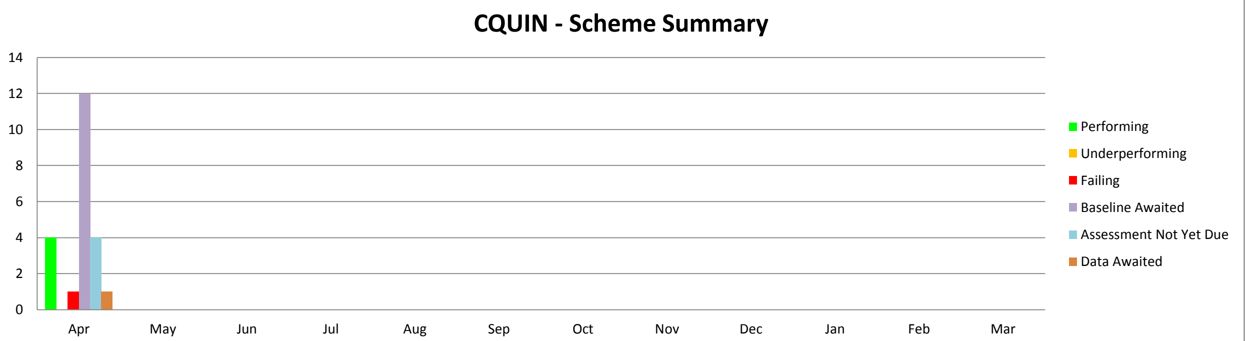
CQUIN (I)

Data Source	Data Quality	PAF	Indicator	Trajectory		Previous Months Trend												Data Period	Group								Month	Year To Date	Trend	Next Month	3 Months
				Year	Month	A	M	J	J	A	S	O	N	D	J	F	M		M	A	B	W	P	I	C	CO					
8			FFT - Implementation of Staff FFT	Implement by end July																											
8			FFT - Early Implementation of Patient FFT in OP / DC Departments	Implement by end Oct																											
8			FFT - Increase and / or Maintain Response Rate in ED areas	>Q1 rate		●												Apr-14									15	15	●		
8			FFT - Increase and / or Maintain Response Rate in IP areas	>Q1 rate		●												Apr-14									36	36	●		
8			FFT - Reduce Negative Responses (ED, IP and Mat'y) (%)	0		Derive base data																									
8			NHS Safety Thermometer - Reduction in Prevalance of Pressure Ulcers	50% reduction		Derive base data																									
8			Dementia - Find, Assess and Refer	=>90	=>90	●												Apr-14									2 of 3 met	2 of 3 met	●		
8			Dementia - Clinical Leadership and Staff Training			Confirm training req's												Apr-14									Clinician in place	Clinician in place	●		
8			Dementia - Supporting Carers of People with Dementia	Monthly Audit	Monthly Audit																										
9			Learning From Safeguarding Concerns	Quarterly report to Board																											
2			Quality of Outpatient and Discharge Letters			Derive base data																									
4			Sepsis - Use of Sepsis Care Bundles			Derive base data																									
8			Pain Relief - Use of Pain Care Bundles			Derive base data																					On Track	On Track	●		
9			Medication and Falls			Derive base data																									
9			Serious Untoward Incidents			Derive base data																									
14			Community Therapies - Effective Referral Management			Derive base data																									

CQUIN (II) and summary

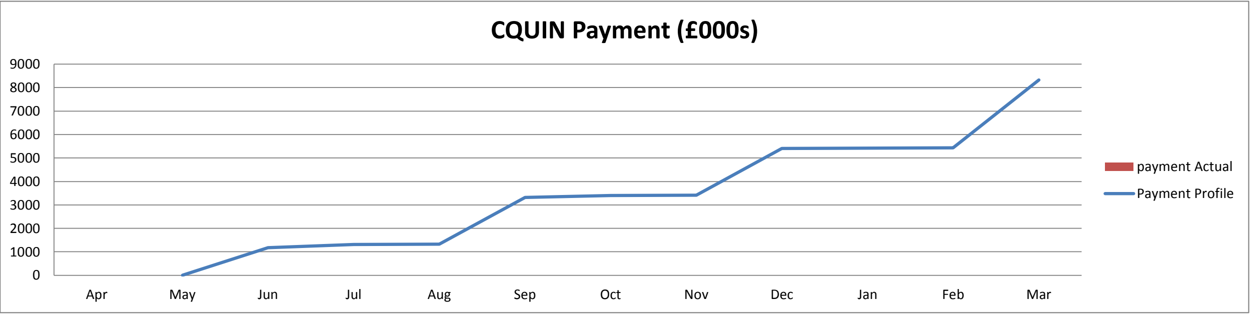
Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
14			Community Therapies - Community Dietetics			Derive base data																									
12			Maternity - Low Risk Births	Quarterly audit / action plan		Base data																									
16			Bechet's Disease	Submit Quarterly return		Quarterly Return																									
17			HIV Home Delivery Medicines (% patients receiving)	70		Derive base data																									
17			Retinopathy of Prematurity Screening (%)	95		Derive base data																									
17			Timely Administration of TPN for preterm infants	95		Derive base data																									



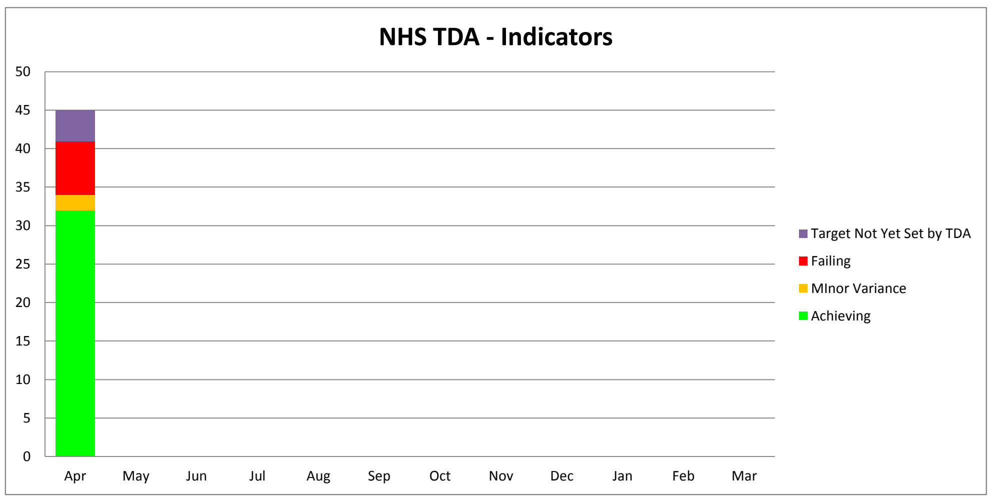


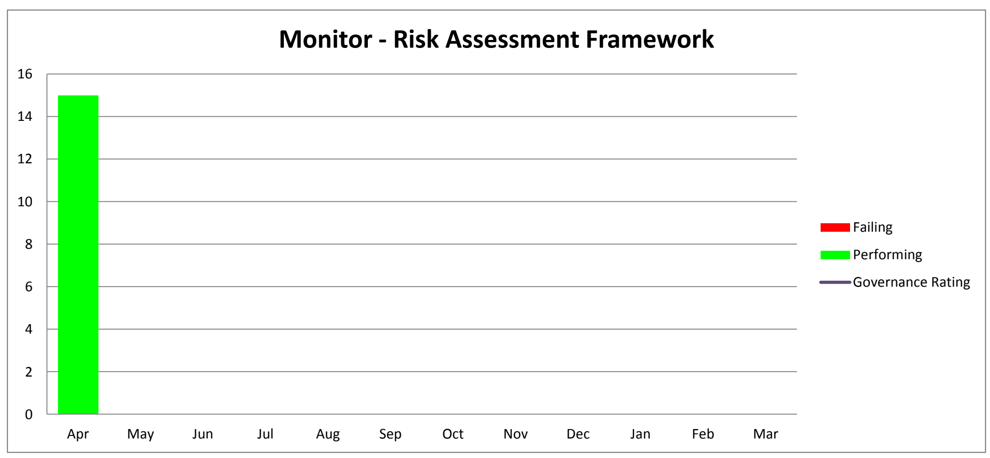
The Trust is contracted to deliver a total of 22 CQUIN schemes during 2014 / 2015. 9 schemes are nationally mandated, a further 9 have been agreed locally, with the remaining 4 identified by the West Midlands Specialised Commissioners. The collective financial value of the schemes is c.£8.3m.

A significant number of the schemes require an initial baseline assessment during quarter 1, following which an improvement trajectory willl be agreed with commissioners.



External Assessment Frameworks





NHS TDA Accountability Framework

NHS TDA Accountability Framework for 2014 / 2015 comprises 3 principal elements; Quality Score, Finance RAG Assessment and Sustainability Score, each of which contribute to the derivation of an Overall Escalation Score. The Quality Score comprises 5 component scores; Caring, Effective, Response, Safe and Well-led, each of which comprise a variable number of metrics. It is intended that individual organisations will be able to score their own performance, although how to do this, and the thresholds for a number of individual metrics have not yet been published.

Metrics within the framework which are currently identified as outside of operational thresholds are:

- There were 9 Open CAS Alerts reported at the end of April
- The Trust's FFT Response Rate and Score in ED is 14.8% and 47.0 respectively
- A total of 36 Mixed Sex Accommodation Breaches were reported during the month
- There was a breach of the 28-day cancelled operation guarantee in Plastic Surgery
- At the end of March an Ophthalmology patients wait for treatment exceeded 52 weeks
- Overall Sickness Absence for the 12-month cumulative period is 4.33% (4.38% in March)

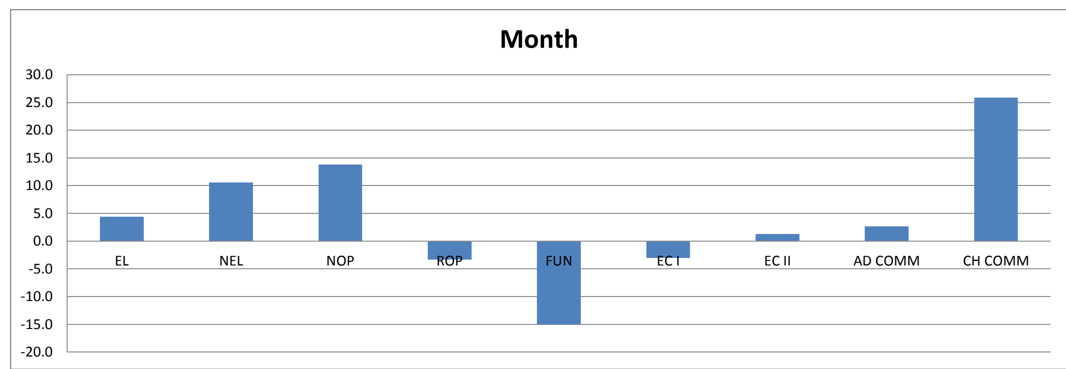
Monitor Risk Assessment Framework

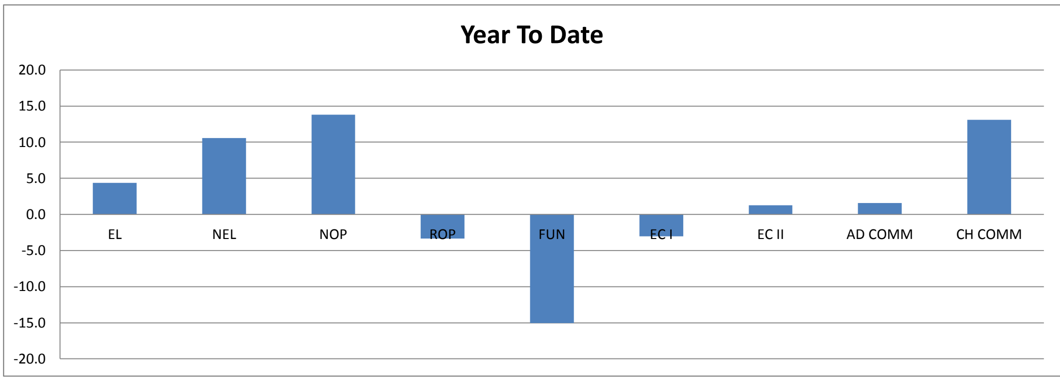
Monitor introduced its ***Risk Assessment Framework*** for NHS Foundation Trusts with effect from 1 October 2013, which replaced its previous Compliance Framework. The range of indicators utilised by Monitor within this framework is less extensive than those used by the NHS TDA. The Access and Outcome metrics used by Monitor have thresholds identified and weightings attributed.

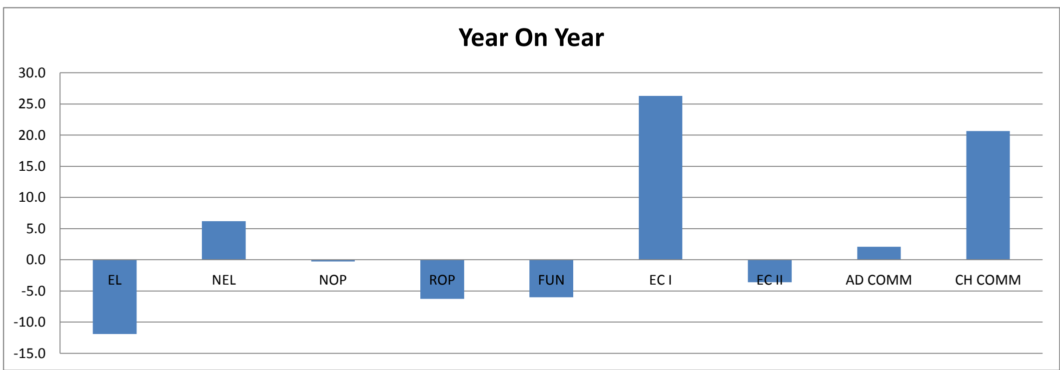
During the month of April the Trust met, or is projected (Cancer and RTT targets) to meet the required thresholds for each of the Access and Outcomes indicators. This would attract an overall weighted score for the month of 0.0 with a GREEN Governance Rating.

Governance Rating	Green (0.0)		Amber / Green (1.0 - 1.9)	
	Amber / Red (2.0 - 3.9)		Amber / Red (>3.9)	

Activity Summary





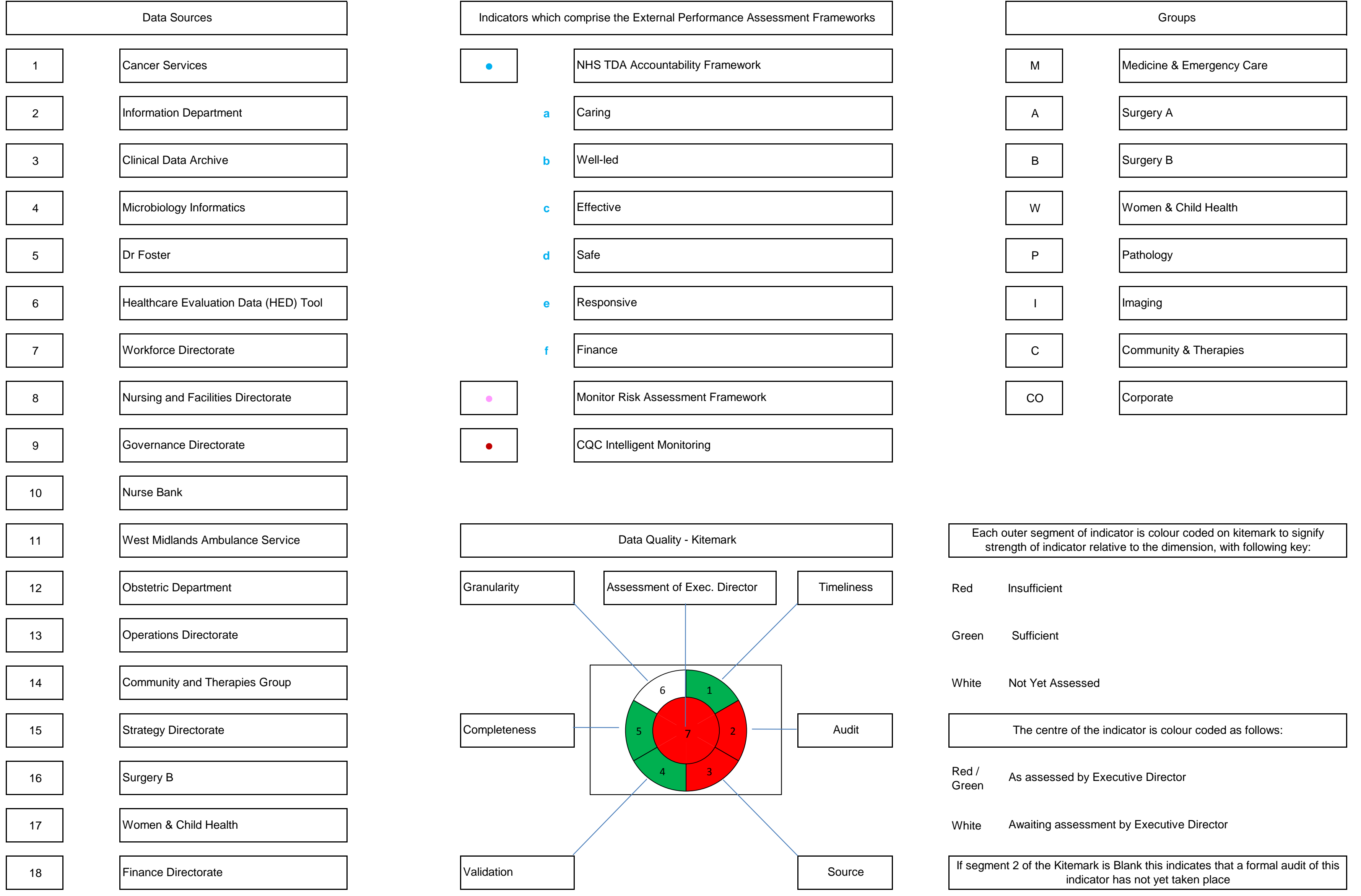


Activity - Variance expressed as a percentage between actual activity and planned (contracted) activity is reflected for the month and year to date in the graphs opposite. Additionally, there is a year on year comparison of current year with previous year for the corresponding period of time. High level Elective activity exceeds the plan for the month by 4.4%, although is (11.9%) less than that delivered during the corresponding period last year, in part accounted for by a lesser number of 'working' days during the month. Non-Elective activity during the month is 10.6% greater than plan, and 6.2% higher than the corresponding period last year. New outpatient attendance numbers are essentially on plan, but with an underperformance of 6.3% against plan for Outpatient Review attendances, a reduced Follow Up to New Outpatient Ratio of 2.25, is less than that (2.65) derived from the plan for the period. Type I and Type II Emergency Care activity for the month is 3.0% less and 1.3% greater than plan respectively, although Type I recorded activity is 26.3% greater than for the corresponding month last year, principally due to the inclusion within the plan of GP Triage activity on both sites. Adult Community and Child Community activity exceeded plans for 2013 / 2014 by 1.6% and 13.1% respectively.

Finance Summary

Data Source	Data Quality	PAF	Indicator	Trajectory		Previous Months Trend												Data Period	Group								Month	Year To Date	Trend	Next Month	3 Months
				Year	Month	A	M	J	J	A	S	O	N	D	J	F	M		M	A	B	W	P	I	C	CO					
18		•f	Bottom Line Income & Expenditure position - Forecast compared to plan																												
18		•f	Bottom Line Income & Expenditure position - Year to Date Actual compared to plan																												
18		•f	Actual efficiency recurring / non-recurring compared to plan - Year to Date actual compared to plan																												
18		•f	Actual efficiency recurring / non-recurring compared to plan - Forecast compared to plan																												
18		•f	Forecast underlying surplus / deficit compared to plan																												
18		•f	Forecast year end charge to capital resource limit																												
18		•f	Is the Trust forecasting permanent PDC for liquidity purposes?																												
18		•b	Temporary costs and overtime as % total paybill																												

Legend



Data Sources	
1	Cancer Services
2	Information Department
3	Clinical Data Archive
4	Microbiology Informatics
5	Dr Foster
6	Healthcare Evaluation Data (HED) Tool
7	Workforce Directorate
8	Nursing and Facilities Directorate
9	Governance Directorate
10	Nurse Bank
11	West Midlands Ambulance Service
12	Obstetric Department
13	Operations Directorate
14	Community and Therapies Group
15	Strategy Directorate
16	Surgery B
17	Women & Child Health
18	Finance Directorate

Indicators which comprise the External Performance Assessment Frameworks	
●	NHS TDA Accountability Framework
a	Caring
b	Well-led
c	Effective
d	Safe
e	Responsive
f	Finance
●	Monitor Risk Assessment Framework
●	CQC Intelligent Monitoring

Groups	
M	Medicine & Emergency Care
A	Surgery A
B	Surgery B
W	Women & Child Health
P	Pathology
I	Imaging
C	Community & Therapies
CO	Corporate

Data Quality - Kitemark

Each outer segment of indicator is colour coded on kitemark to signify strength of indicator relative to the dimension, with following key:

Red	Insufficient
Green	Sufficient
White	Not Yet Assessed

The centre of the indicator is colour coded as follows:

Red / Green	As assessed by Executive Director
White	Awaiting assessment by Executive Director

If segment 2 of the Kitemark is Blank this indicates that a formal audit of this indicator has not yet taken place

Medicine Group

Indicator	Trajectory		Previous Months Trend												Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		EC	AC	SC					
C. Difficile	30	3	●	●	●	●	●	●	●						Apr-14	0	0	1	1	1	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●						Apr-14	0	0	0	0	1	●		
MRSA Screening - Elective (%)	80	80	●	●	●	●	●	●	●						Apr-14	24	83	44	60		●		
MRSA Screening - Non Elective (%)	80	80	●	●	●	●	●	●	●						Apr-14	94	96	96	94.65		●		
Falls	0	0							33						Apr-14	7	19	7	33	33	●		
Falls with a serious injury	0	0	5	2	5	1	1	1	1						Apr-14	0	0	1	1	1	●		
Grade 3 or 4 Pressure Ulcers (avoidable)	0	0				0	0								Feb-14	0	0	0	0		●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	99	99	99	99		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●						Apr-14	100	99	100	99.8		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	100	98.0	100	99.6		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●						Apr-14	100	98.0	100	99.6		●		
Never Events	0	0	●	●	●	●	●	●	●						Apr-14	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●						Apr-14	0	0	0	0	0	●		
Serious Incidents	0	0					●								Jan-14	0	0	0	0				
Open Serious Incidents Requiring Investigation (SIRI)	0	0					●								Jan-14	0	0	0	0				
Mortality Reviews within 42 working days	=>80.0	=>80.0	●	●	●	●	●								Feb-14	72.0	80.0	71.0	75.0		●		
Pts spending >90% stay on Acute Stroke Unit (%)	=>90.0	=>90.0	●	●	●	●	●	●	●						Apr-14		75.5		75.5	75.5	●		
Pts admitted to Acute Stroke Unit within 4 hrs (%)	=>90.0	=>90.0	●	●	●	●	●	●	●						Apr-14		74.5		74.5	74.5	●		
Pts receiving CT Scan within 1 hr of presentation (%)	=>50.0	=>50.0	●	●	●	●	●	●	●						Apr-14		74.5		74.5	74.5	●		
Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●						Apr-14		100		100.0	100.0	●		
Stroke Admission to Thrombolysis Time (% within 60 mins)	=>85.0	=>85.0	●	●	●	●	●	●	●						Apr-14		100		100.0	100.0	●		
Stroke Admissions - Swallowing assessments (<24h) (%)	=>98.0	=>98.0	●	●	●	●	●	●	●						Apr-14		100		100.0	100.0	●		
TIA (High Risk) Treatment <24 Hours from initial presentation (%)	=>70.0	=>70.0	●	●	●	●	●	●	●						Apr-14		88.5		88.5	88.5	●		
TIA (Low Risk) Treatment <7 days from initial presentation (%)	=>75.0	=>75.0	●	●	●	●	●	●	●						Apr-14		93.3		93.3	93.3	●		
Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●							Mar-14		58(C) 90(S)		58 (C) & 90 (S)		●		
Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●							Mar-14		60(C) 100(S)		60 (C) & 100 (S)		●		
Rapid Access Chest Pain - seen within 14 days (%)	=>98.0	=>98.0	●	●	●	●	●	●							Mar-14		92.0		92.0	95.7	●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●							Mar-14			92	91.9		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●							Mar-14			100	100.0		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●							Mar-14			83	83.3		●		

Indicator	Trajectory Year	Trajectory Month	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Directorate EC	Directorate AC	Directorate SC	Month	Year To Date	Trend	Next Month	3 Months
FFT Response Rate																							
FFT Score																							
Mixed Sex Accommodation Breaches	0	0	5	4	2	3	7	21	36						Apr-14	0	36	0	36	36	●		
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●						Apr-14	1.20	3.24	0.13	0.54		●		
28 day breaches	0	0	●	●	●	●	●	●	●						Apr-14	0	0	0	0	0	●		
Sitrep Declared Late Cancellations	0	0	13	2	2	7	7	4	10						Apr-14	2	6	2	10	10	●		
Emergency Care 4-hour waits (%)	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	95.6 (s)	95.2 (c)		95.9	95.9	●		
Emergency Care Trolley Waits >12 hours	0	0	●	●	●	●	●	●	●						Apr-14	0 (s)	0 (c)		0	0	●		
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins	●	●	●	●	●	●	●						Apr-14	17 (s)	21 (c)		19	19	●		
Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins	●	●	●	●	●	●	●						Apr-14	51 (s)	52 (c)		46	46	●		
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●						Apr-14	7.07 (s)	5.09 (c)		5.58	5.58	●		
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●						Apr-14	3.27 (s)	4.00 (c)		3.33	3.33	●		
WMAS - Handovers (emergency conveyances) 30 - 60 mins (number)	0	0	●	●	●	●	●	●	●						Apr-14	49 (s)	67 (c)		116	116	●		
WMAS - Handovers (emergency conveyances) >60 mins (number)	0	0	●	●	●	●	●	●	●						Apr-14	8 (s)	7 (c)		15	15	●		
WMAS - Turnaround (emergency conveyance) Delays 30 - 60 mins	0	0	●	●	●	●	●	●	●						Apr-14	500 (s)	767 (c)		1267	1267	●		
WMAS - Turnaround (emergency conveyance) Delays >60 mins	0	0	●	●	●	●	●	●	●						Apr-14	9 (s)	16 (c)		25	25	●		
WMAS - Turnaround Delays > 60 mins (% all journeys)	=<0.02	=<0.02	●	●	●	●	●	●	●						Apr-14	0.48 (s)	0.71 (c)		0.62		●		
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●						Apr-14	98.1	91.5	96.4	95.0		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	66.7	89.0	95.5	92.8		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●						Apr-14	95.3	87.9	95.3	92.2		●		
Patients Waiting >52 weeks	0	0	17	6	4	0	0	0	0						Apr-14	0	0	0	0		●		
Treatment Functions Underperforming	0	0	4	5	4	4	5	5	6						Apr-14	1	2	3	6		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●						Apr-14	0.00	2.48	1.74	1.31		●		
WTE - Actual versus Plan			176	158	165	135	163								Feb-14				163				
PDRs - 12 month rolling (%)	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	92	95	96		93	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	100	100	100		100	●		
Sickness Absence (%)	=<3.15	=<3.15	●	●	●	●	●	●	●						Apr-14	3.40	3.76	4.11	3.76	4.11	●		
Mandatory Training (%)	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	82	84	80		82	●		
New Investigations in Month			2	0	0	0	0								Feb-14				0				
Nurse Bank Use	34560	2880	●	●	●	●	●	●	●						Apr-14				2769	2769	●		
Nurse Agency Use	7423	619	●	●	●	●	●	●	●						Apr-14				2177	2177	●		
Your Voice - Response Rate (%)			11		8										Feb-14	7	6	9	8	8			
Your Voice - Overall Score			3.73		3.68										Feb-14	3.7	3.8	3.6	3.68	3.68			

Surgery A Group

Indicator	Trajectory Year	Trajectory Month	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Directorate A	Directorate B	Directorate C	Directorate D	Month	Year To Date	Trend	Next Month	3 Months
C. Difficile	7	1	●	●	●	●	●	●	●						Apr-14	2	0	0	0	2	2	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●						Apr-14	0	0	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●						Apr-14	99	99	77	0	92.6		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●						Apr-14	96	93	91	78	94.3		●		
Falls	0	0							9						Apr-14	2	5	2	0	9	9	●		
Falls with a serious injury	0	0	1	0	1	1	0	1	0						Apr-14	0	0	0	0	0	0	●		
Grade 3 or 4 Pressure Ulcers (avoidable)	0	0				3	0								Feb-14	0	0	0	0	0				
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	98	99	99	99	99		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●						Apr-14	100	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	100	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●						Apr-14	100	100	100	100	100		●		
Never Events	0	0	●	1	●	●	●	●	●						Apr-14	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●						Apr-14	0	0	0	0	0	0	●		
Serious Incidents	0	0				●									Jan-14	0	0	1	0	1				
Open Serious Incidents Requiring Investigation (SIRI)	0	0				●									Jan-14	0	1	1	0	2				
Mortality Reviews within 42 working days	=>80.0	=>80.0	●	●	●	●	●								Feb-14	66	85		92	87.0		●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●							Mar-14	98		96		97.1		●		
2 weeks (Breast Symptomatic)	=>93.0	=>93.0	●	●	●	●	●	●							Mar-14	98.1				98.1		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●							Mar-14	100		100		100.0		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●							Mar-14	95		92.3		88.2		●		
FFT Response Rate																								
FFT Score																								
Mixed Sex Accommodation Breaches	0	0	12	5	2	3	3	0	0						Apr-14	0	0	0	0	0	0	●		
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●						Apr-14	0.8	1.8	0.6	0.8	0.96		●		
28 day breaches	0	0	0	0	0	0	0	1	1						Apr-14	1	0	0	0	1	1	●		
Sitrep Declared Late Cancellations	0	0	28	35	25	28	37	18	13						Apr-14	5	5	2	1	13	13	●		
Weekday Theatre Utilisation	=>80.0	=>80.0	●	●	●	●	●	●	●						Apr-14	81	78	74		76		●		
Hip Fractures - Operation < 24 hours of admission (%)	85	85	●	●	●	●	●	●	●						Apr-14		64.3			64.3	64.3	●		

Indicator	Trajectory		Previous Months Trend												Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		A	B	C	D					
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●						Apr-14	85.9	56.1	96.5		79.8		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	97.1	93.3	90.7		94.5		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●						Apr-14	93.1	83.6	94.3		89.1		●		
Patients Waiting >52 weeks	0	0	28	13	3	3	0	0	1						Apr-14	1	0	0	0	1	1	●		
Treatment Functions Underperforming	0	0	5	8	8	7	8	7	7						Apr-14	3	3	1	0	7		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●						Apr-14	5.30	0.00	21.9	0.00	10.3		●		
WTE - Actual versus Plan			70	71	72	88	76								Feb-14					76				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	92	86	95	92		92	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	100	100	100	100		100	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●						Apr-14	3.51	5.07	6.32	6.03	5.37	5.22	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	82	82	89	88		86	●		
New Investigations in Month			0	0	2	1	1								Feb-14					1				
Nurse Bank Use	9908	826	●	●	●	●	●	●	●						Apr-14					768	768	●		
Nurse Agency Use	1144	95	●	●	●	●	●	●	●						Apr-14					483	483	●		
Your Voice - Response Rate			16			13									Feb-14	11	10	8	17	13	13			
Your Voice - Overall Score			3.03			3.55									Feb-14	3.6	3.7	3.8	3.4	3.55	3.55			

Surgery B Group

Indicator	Trajectory Year	Trajectory Month	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Directorate O	Directorate E	Month	Year To Date	Trend	Next Month	3 Months
C. Difficile	0	0	●	●	●	●	●	●	●						Apr-14	0	0	0	0	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●						Apr-14	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●						Apr-14	87	95	92.2		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●						Apr-14	92	93	92.4		●		
Falls	0	0							1						Apr-14	1	0	1	1	●		
Falls with a serious injury	0	0	0	0	0	0	0	0	0						Apr-14	0	0	0	0	●		
Grade 3 or 4 Pressure Ulcers (avoidable)	0	0				0	0								Feb-14	0	0	0				
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	98	99	99		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●						Apr-14	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	99	100	99		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●						Apr-14	99	100	99		●		
Never Events	0	0	●	1	●	●	●	●	●						Apr-14	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●						Apr-14	0	0	0	0	●		
Serious Incidents	0	0				●									Jan-14	1	0	1				
Open Serious Incidents Requiring Investigation (SIRI)	0	0				●									Jan-14	1	0	1				
Mortality Reviews within 42 working days	=>80.0	=>80.0	●	●	●	●	●								Feb-14		0	0		●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●							Mar-14		82.4	82.4		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●			●	●							Mar-14		100	100.0		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0		●	●	●	●	●							Mar-14		80	80.0		●		
FFT Response Rate																						
FFT Score																						
Mixed Sex Accommodation Breaches	0	0	●	●	●	●	●	●	●						Apr-14	0	0	0	0	●		
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●						Apr-14	0.5	0	0.3		●		
28 day breaches	0	0	0	0	0	0	0	0	0						Apr-14	0	0	0	0	●		
Sitrep Declared Late Cancellations	0	0	19	14	19	36	15	22	3						Apr-14	3	0	3	3	●		
Weekday Theatre Utilisation	=>80.0	=>80.0	●	●	●	●	●	●	●						Apr-14	75	72	73		●		

Indicator	Trajectory		Previous Months Trend												Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		O	E					
Emergency Care 4-hour waits (%)	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	100		99.7	99.7	●		
Emergency Care Trolley Waits >12 hours	0	0	●	●	●	●	●	●	●						Apr-14	0		0	0	●		
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins	●	●	●	●	●	●	●						Apr-14	14		14	14	●		
Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins	●	●	●	●	●	●	●						Apr-14	20		20	20	●		
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●						Apr-14	2.65		2.65	2.65	●		
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●						Apr-14	1.4		1.38	1.38	●		
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●						Apr-14	90	93	90.6		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	99	97	98.4		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●						Apr-14	96	91	94.2		●		
Patients Waiting >52 weeks	0	0	9	9	2	0	1	1	0						Apr-14	0	0	0	0	●		
Treatment Functions Underperforming	0	0	1	0	0	2	3	3	3						Apr-14	1	2	3		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●							Apr-14	0.00	0.93	0.93		●		
WTE - Actual versus Plan			31	24	23	27	37								Feb-14			37				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	97	96		97	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	85	100		87.0	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●						Apr-14	3.2	0.9	2.51	3.03	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	84	94		86	●		
New Investigations in Month			0	0	0	1	0								Feb-14			0				
Nurse Bank Use	2796	233	●	●	●	●	●	●	●						Apr-14			211	211	●		
Nurse Agency Use	71	6	●	●	●	●	●	●	●						Apr-14			73	73	●		
Your Voice - Response Rate			17		18										Feb-14	10	37	18	18			
Your Voice - Overall Score			3.66		3.72										Feb-14	3.7	3.7	3.72	3.72			

Women & Child Health Group

Indicator	Trajectory Year	Trajectory Month	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Directorate G	Directorate M	Directorate P	Directorate C	Month	Year To Date	Trend	Next Month	3 Months
C. Difficile	0	0	●	●	●	●	●	●	●						Apr-14	0	0	0	0	0	0	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●						Apr-14	0	0	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●						Apr-14	96				95.95		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●						Apr-14	97	97			97.22		●		
Falls	0	0							0						Apr-14	0	0	0	0	0	0	●		
Falls with a serious injury	0	0	0	0	0	0	0	0	0						Apr-14	0	0	0	0	0	0	●		
Grade 3 or 4 Pressure Ulcers (avoidable)	0	0				0	0								Feb-14	0	0	0	0	0				
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	96	92			94		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●						Apr-14	100		100		100		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	100		100		100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●						Apr-14	100		100		100		●		
Never Events	0	0	●	●	●	●	●	●	●						Apr-14	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●						Apr-14	0	0	0	0	0	0	●		
Serious Incidents	0	0				●									Jan-14	1	1	0	0	2				
Open Serious Incidents Requiring Investigation (SIRI)	0	0				●									Jan-14	1	1	0	0	2				
Caesarean Section Rate - Total (%)	=<25.0	=<25.0	●	●	●	●	●	●	●						Apr-14		26			26.2	26.2	●		
Caesarean Section Rate - Elective (%)			11	10	11	12	11	10	14						Apr-14		14			14.4	14.4			
Caesarean Section Rate - Non Elective (%)			13	15	10	16	14	13	12						Apr-14		12			11.9	11.9			
Maternal Deaths	0	0	●	●	●	●	●	●	●						Apr-14		0			0	0	●		
Post Partum Haemorrhage (>2000ml)	48	4	●	●	●	●	●	●	●						Apr-14		0			0	0	●		
Admissions to Neonatal Intensive Care (%)	=<10.0	=<10.0	●	●	●	●	●	●							Mar-14		14			13.9	10.7	●		
Adjusted Perinatal Mortality Rate (per 1000 babies)	<8.0	<8.0	●	●	●	●	●								Feb-14		6.8			6.8		●		
Early Booking Assessment (<12 + 6 weeks) (%)	=>90.0	=>90.0	●	●	●	●	●								Feb-14		145			145		●		
Mortality Reviews within 42 working days	=>80.0	=>80.0	●	●	●	●	●								Feb-14	100				100		●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●							Mar-14	99				98.5		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●							Mar-14	100				100.0		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●							Mar-14	100				100.0		●		
FFT Response Rate																								
FFT Score																								
Mixed Sex Accommodation Breaches	0	0	●	●	●	●	●	●	●						Apr-14	0				0	0	●		

Indicator	Trajectory		Previous Months Trend												Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		G	M	P	C					
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●						Apr-14	5.4				4.36		●		
28 day breaches	0	0	0	0	0	0	0	0	0						Apr-14	0				0	0	●		
Sitrep Declared Late Cancellations	0	0	4	13	14	13	7	12	12						Apr-14	12				12	12	●		
Weekday Theatre Utilisation	=>80.0	=>80.0	●	●	●	●	●	●	●						Apr-14	83				83		●		
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●						Mar-14	93				93.1		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●						Mar-14	95.7				95.7		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●						Mar-14	98				97.9		●		
Patients Waiting >52 weeks	0	0	4	4	2	0	0	0	0						Apr-14	0				0	0	●		
Treatment Functions Underperforming	0	0	0	0	0	0	0	0	0						Apr-14	0				0		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●						Apr-14	0.0				0.0		●		
WTE - Actual versus Plan			64	39	42	41	34								Feb-14					34				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	88	95	94	94		94	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	100	100	100			100	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●						Apr-14	3.69	4.37	5.86	3.55	4.24	4.49	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	88	85	88	88		86	●		
New Investigations in Month			1	0	0	0	0								Feb-14					0	5			
Nurse Bank Use	6852	571	●	●	●	●	●	●	●						Apr-14					503	503	●		
Nurse Agency Use	184	15	●	●	●	●	●	●	●						Apr-14					77	77	●		
Your Voice - Response Rate			17			11									Feb-14	18	4	18	16	11	11			
Your Voice - Overall Score			3.74			3.79									Feb-14	3.5	3.9	3.9	3.8	3.79	3.79			

Pathology Group

Indicator	Trajectory		Previous Months Trend												Data Period	Directorate					Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		HA	HI	B	M	I					
Never Events	0	0	●	●	●	●	●	●	●						Apr-14	0	0	0	0	0	0	0	●		
Open Serious Incidents Requiring Investigation (SIRI)	0	0				●									Jan-14	0	0	0	0	0	0	0			
WTE - Actual versus Plan			31	32	30	37	33								Feb-14						33				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	100	100	91	100	94		97	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	100	100	100	100	100		100	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●						Apr-14	4.22	2.60	4.26	3.44	0.00	3.57	4.16	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	97	95	92	94	99		95	●		
New Investigations in Month			0	0	0	0	0								Feb-14						0				
Your Voice - Response Rate			17		36										Feb-14	36	32	34	52	53	36	36			
Your Voice - Overall Score			3.31		3.6										Feb-14	3.4	3.6	3.6	3.6	3.9	3.60	3.60			

Imaging Group

Indicator	Trajectory		Previous Months Trend												Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		DR	IR	NM	BS					
Never Events	0	0	●	●	●	●	●	●	●						Apr-14	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●						Apr-14	0	0	0	0	0	0	●		
Open Serious Incidents Requiring Investigation (SIRI)	0	0				●									Jan-14	0	0	0	0	0	0			
Pts receiving CT Scan within 1 hr of presentation (%)	=>50.0	=>50.0	●	●	●	●	●	●	●						Apr-14					74.5	74.5	●		
Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●						Apr-14					100.0	100.0	●		
Mixed Sex Accommodation Breaches	0	0	●	●	●	●	●	●	●						Apr-14	0	0	0	0	**0**	**0**	●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●						Apr-14	0.3				0.25		●		
WTE - Actual versus Plan			26	20	21	18	28								Feb-14					28				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	95	92	97	100		97	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	96		100			97.0	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●						Apr-14	3.6	3.9	1.79	5.1	4.38	4.43	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	90	92	94	93		92	●		
New Investigations in Month			0	0	1	0	0								Feb-14					0				
Nurse Bank Use	288	24	●	●	●	●	●	●	●						Apr-14					19	19	●		
Nurse Agency Use	752	63	●	●	●	●	●	●	●						Apr-14					132	132	●		
Your Voice - Response Rate			30		19										Feb-14	14		57		19	19			
Your Voice - Overall Score			3.73		3.72										Feb-14	3.8		3.9		3.72	3.72			

Community & Therapies Group

Indicator	Trajectory		Previous Months Trend												Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S										
MRSA Screening - Elective	80	80	●	●	●	●	●	●							Mar-14					100		●		
Patient Safety Thermometer - Overall Harm Free Care	=>92	=>92	91	90	92	94	93	92							Mar-14					92.14		●		
Falls	=<0.4	=<0.4	0.4	0.2	0.0	0.0	0.2	0.0							Mar-14					0.0	0.2	●		
Pressure Ulcers	=<7.0	=<7.0	8.9	9.5	7.5	5.6	6.9	8.7							Mar-14					8.7	7.6	●		
Never Events	0	0	●	●	●	●	●	●	●						Apr-14					0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●						Apr-14					0	0	●		
Open Serious Incidents Requiring Investigation (SIRI)	0	0	●	●	●	●	●	●							Mar-14					0	0	●		
FFT Response Rate - Wards	=>28.0	=>28.0	19	13	15	13	6	22							Mar-14					22	17	●		
FFT Score - Wards	=>68.0	=>68.0	94	100	93	85	83	82							Mar-14					82	88	●		
Mixed Sex Accommodation Breaches	0	0	●	●	●	●	●	●	●						Apr-14					0	0	●		
WTE - Actual versus Plan			55	70	32	34	34								Feb-14					34				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14						96	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14						100	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●						Apr-14					4.50	4.07	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14						91	●		
New Investigations in Month			0	0	1	0	1								Feb-14					1	3			
Nurse Bank Use	5408	451	●	●	●	●	●	●	●						Apr-14					273	273	●		
Nurse Agency Use	3282	273	●	●	●	●	●	●	●						Apr-14					269	269	●		
Your Voice - Response Rate			28		18										Feb-14					18	18			
Your Voice - Overall Score			3.71		3.75										Feb-14					3.75	3.75			
DVT numbers	730	>61			30	40	57	53	53						Apr-14					53	53	●		
Therapy DNA rate OP services (%)	=<9	=<9					11	12	12						Apr-14					12.28	12.28	●		
FEES assessment	>100	>8.3						1	7						Apr-14					7	7	●		
ESD Response time	<48 hrs	<48 hrs				●	●								Feb-14							●		
STEIS	0	0			2	0	0	1	0						Apr-14					0	0	●		
Rapid response to AMU, RRTS	<60 mins	<60 mins			77	75	75	75	75						Apr-14					75	75	●		
Avoidable weight loss	<20%	<20%		●	●	●	●	●	●						Apr-14					18	18	●		
Expansion of FF to Physio outpatients																								
Green Stream Community Rehab response time for treatment (days)	=<11	=<11					15	11	12						Apr-14					11.8	11.8	●		

Corporate Group

Indicator	Trajectory		Previous Months Trend												Data Period	Directorate							Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		CEO	F	W	M	E	N	O					
Open Serious Incidents Requiring Investigation (SIRI)	0	0																									
WTE - Actual versus Plan			191	215	187	161	164								Feb-14								164				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	95	99	90	92	96	98	94		96	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14			100						100	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●						Apr-14	4.42	0.76	1.86	2.95	1.32	4.54	4.60	3.87	4.20	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●						Apr-14	95	92	95	88	99	88	92		90	●		
Nurse Bank Use	1088	91	●	●	●	●	●	●	●						Apr-14								130	130	●		
Nurse Agency Use	55	5	●	●	●	●	●	●	●						Apr-14								9	9	●		
New Investigations in Month			0	1	0	0	2								Feb-14								2	8			
Your Voice - Response Rate						26									Feb-14	58	27	51	36	29	20	22	26	26			
Your Voice - Overall Score						3.56									Feb-14	3.68	3.51	3.50	3.47	3.63	3.57	3.56	3.56	3.56			

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	18 week update
SPONSOR (EXECUTIVE DIRECTOR):	Rachel Barlow Chief Operating Officer
AUTHOR:	Rachel Barlow Chief Operating Officer
DATE OF MEETING:	5 June 2014

EXECUTIVE SUMMARY:

The Trust has demonstrated a track record of compliance at Trust level for 18-weeks referral to Treatment (RTT) for admitted, non-admitted and incomplete pathways.

Compared to the national position we are doing better than most trusts, with the national position for 18 weeks underperforming in admitted care within Q4

However, our waiting list remains static and at specialty level we have several points of underperformance and meeting the standards is challenging without redesigning what we do. We said we would improve our performance position in Q3 and Q4. Some specialities have made good progress but some are performing less well than we anticipated.

This paper provides an update on the plan to meet 18 weeks both in terms of access to services and quality of care particularly;

- what was the plan, where we are not meeting it how do we make the progress we need to
- What is the basis for improvement
- Are there any safety concerns in non-admitted waits
- How much might this cost

REPORT RECOMMENDATION:

The Board is asked to consider the briefing and discuss the challenges related to 18 weeks

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		x

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	x	Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	x
Clinical	x	Equality and Diversity		Workforce	

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Risk register and previous board discussion and presentations related to 18 week performance

PREVIOUS CONSIDERATION:

Previously considered by the Trust Board as part of the performance report.

18 Week Referral to Treatment plan

REPORT TO THE TRUST BOARD – 5 JUNE 2014

1.Introduction

The Trust has demonstrated a track record of compliance at Trust level for 18 weeks Referral to Treatment (RTT) for admitted, non-admitted and incomplete pathways (see appendix 1). Compared to the national position we are doing better than most trusts, with the national position for 18 weeks underperforming in admitted care within Q4. At Trust level our waiting list size remains largely unchanged since the historical validation exercise was completed in September 2013. However at specialty level we have several points of underperformance and meeting the standards is challenging without redesigning what we do. We said we would improve our performance position in Q3 and Q4. Some specialities have made good progress but some are performing less well than we anticipated. This paper provides an update on the plan to meet 18 weeks both in terms of access to services and quality of care.

2. What is the plan to meet 18 weeks

a. Trust Performance Projected performance in 18 weeks RTT for the Trust has been modelled as providing overall compliance with the national standards. The Trust level trajectory is outlined in Table 1 below:

Table 1: Trust Projected (April Actual) Activity and % Outturn 2014/15

	April (Actual)	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Clock Stops (Trust)	**10,532**	10,463	10,463	11,327	9,462	10,301	12,021	11,923	10,171	10,500	10,495	11,414
Waiting List (Trust)	**30,636**	29,430	29,430	29,527	29,100	29,070	29,030	29,000	28,700	28,500	28,250	27,978
% Trust Incomplete	**92.68%**	92.2%	92.4%	92.3%	92.7%	93.3%	93.6%	94.2%	92.3%	92.3%	92.3%	92.2%
% Trust Admit	**90.02%**	90.4%	90.8%	90.9%	90.5%	91.4%	91.5%	91.7%	91.7%	91.6%	92.0%	91.6%
% Trust Non Admit	**96.31%**	95.8%	96.6%	95.4%	96.2%	97.1%	97.2%	97.4%	97.5%	97.6%	96.9%	96.2%

b. Specialty level plans: Most specialties do currently meet the 18 week standards. However there are areas of underperformance at specialty level that still need correction. During 2013/14 these specialties were required to submit action plans and trajectories outlining the measures that they would take to recover their position. This originally encompassed nine specialties, however a further area, Oral Surgery, has identified concerns and has latterly submitted a revised performance trajectory.

Specialty level performance
Appendix 2 shows the revised performance profiles broken down by point of pathway ie those patients whose pathway has stopped during an admitted or non-admitted episode, and those patients remaining on an incomplete pathway. The highlighted areas are specialities by point of pathway anticipating underperformance. In May, 12 areas across 6 specialities are anticipating to underperform.

In Q2 Cardiology, T&O and Oral Surgery are forecasting underperformance.

Trust level compliance is expected throughout the year.

3. How are we doing so far in 2014?
In April at Trust level we stopped over 10,000 18 week pathways, 69 above plan. The size of the overall incomplete waiting list was 1210 behind plan with 30640 waiting compared to a plan of 29430.

16 points of underperformance at specialty level were reported in April, with only 11 forecast. The outliers being general surgery, ENT, general medicine, gastroenterology, thoracic medicine and urology.

Effectively this work will need to be recovered in year, some as actual activity and a proportion of uncashed up clinics where patients have been seen but the administration event is not closed particularly in respiratory and cardiology. In patient activity is best profiled in Q2 and Q3 before winter bed pressures.

The recent decrease in validation team is considered a pressure by some Directorates but this is being mitigated through development and training of medical secretaries.

Appendix 3 compares the original activity plans for the patients on an incomplete pathway (ie combined number of patients waiting on non-admitted and admitted pathways) with the revised plan going forward submitted at last week's CLE meeting. These improvement plans must be delivered by working differently outlined in the section 4 below. The recovery from the increase in the waiting list in April needs to be evidenced by delivering new ways of working to avoid further financial risk rather than purely renegotiated delivery plan with a revised demand and capacity alignment. In June the COO and CEO will be meeting all Directors of Operations to lock down these plans.

4. What is the underlying basis for improvement
The performance trajectories that underperforming specialties have developed include a focus on improving pathways and throughput for non-admitted as well as admitted patients.

Continued reliance on waiting list initiatives is not possible and redesign and improved utilisation where there is opportunity is essential. The high volume specialties have some additional capacity in their plan these include cardiology, ophthalmology and orthopaedics.

Direct access and advice and guidance will enable primary care to appropriately diagnose and treat patients in a non-acute setting. This has been partially successful in T&O and cardiology but not realised the reduction in referrals anticipated. The Trust will be working with the CCG to understand this profile.

The quality of GP referrals is an essential first contact with a specialist and high quality referrals can determine better triage opportunities of patients to the correct service or clinician or advise on management in primary care thereby avoiding unnecessary referrals to the acute hospital clinicians.

As part of the Year of Out-Patients programme, a number of technical solutions will be implemented to support Directorates in the management of 18 weeks. This includes electronic referral management which will track clinical triage and the quality of referral management. Incomplete referrals will be returned to the referrer to enable full information to determine how best to manage a referral pathways in either acute or primary care. The Trust will be working with the CCG on the quality of referral management this year.

Partial booking will decrease follow up cancellations and DNAs. Electronic outcome recording will enable better opportunity to tract real time decisions and pathways management which is sometimes left incomplete and becomes part of a delayed validation process.

At specialty and pathway level redesign if essential to reduce follow up and appropriately create earlier discharge back to primary or community care. An example of this is routine blood tests and follow-up virtual clinic by telephone or letter for normal result, rather than attending out patients. The management of long term conditions with patient clinical triggers to access rapid follow up is being explored in key specialities to reduce the ‘routine ‘ follow up as than do not necessarily add clinical value. Patient and carer information will be key to the confidence and assurance of managing long terms conditions across an integrated care setting.

Utilisation of out-patients and theatres needs to be effective. Annualising theatres and job plan schedules has seen an increase in theatre utilisation above 80% for scheduled lists. A similar approach to annualising out-patient session and cover within clinical teams will be delivered this year.

3. Are there any safety concerns in non-admitted waits

Patients on an incomplete pathway are either at a stage where they have a diagnosis and are waiting for in-patient treatment or are still on an out-patient or non-admitted pathway where patients may still be waiting for diagnostics to take place, results of tests to be considered and a treatment plan to be set or a discharge decision to be made back to the GP to stop the referral pathway. Therefore patients waiting a long time on an incomplete pathway who are in the outpatient or non-admitted group, should be of some focus.

As of the 28th May 2057 patients were on an incomplete out- patient pathway and waiting over 18 weeks. This was 92.77% of the out-patient waiting list. 37% of those waiting over 18 weeks were on cardiology, ophthalmology and orthopaedic pathways.

Validation exercises have previously been completed for both ophthalmology and orthopaedics waiting lists. This has 2 outputs, first a clinical validation to prioritise by clinical need the order of patients on the waiting list and secondly an administration validation to ascertain if patient still wants to receive treatment and avoid DNAs or patient cancellations. Neither validation identified clinical risk due to the long waits.

Cardiology has the largest and longest distribution of patients waiting over 18 weeks for diagnosis and treatment or discharge. This is of potential safety concern and the longest waiting times are definitely a poor patient experience. A clinical validation of these patients will be completed within 2 weeks by the specialty to provide clarity on the risk identified in the group of patients waiting over 18 weeks for treatment.

In the meantime the recruitment of additional consultants provides additional capacity in out-patients and the specialty are being supported to deliver sustainable service plans through redesign and improved utilisation, a rather than a reliance on waiting lists and old ways of working. The specialty is being supported by an intensive support programme to ensure delivery and pace of change.

Our longest waits are those patients who wait over 40 weeks for treatment. Over previous weeks approximately 20 patients are identified weekly as waiting over 40 weeks on an open 18 week pathway and whose pathway is planned to be stopped between 40 – 52 weeks. These patients are predominantly on an admitted pathway and 45 % of these are waiting for dated orthopaedic surgery. Again this waiting list has been validated with no clinical risk identified.

5. Financial implications

The additional work outlined in the recovery plans that is unfunded has been costed by each Clinical Group. Additional resources are required by T&O and are expected in cardiology given its current waiting times; the value of this is anticipated at £446K non recurrent. Other specialties are being encouraged to create additional capacity by utilising their existing resources more efficiently. This includes schemes such as annualised hours, improving theatre productivity, pooling lists and reviewing consultant job plans against recognised demand. The lock down of plans in June will be necessary to assure no further financial risk.

6. Commissioner engagement*:*

These specialty level revised trajectories differ from the profiles originally submitted to SWB CCG and the NHS TDA as part of the original recovery plan.

The Trust will be meeting regularly with operational and clinical leaders in the CCG to take forward partnership working to support the delivery plan for 18 weeks.

7. Conclusion

The Trust Board is recommended to note the proposed trajectories and discuss the profile of waiting times and the approach to correct performance at speciality level.

Appendix 1: Trust Waiting list profile

The table below shows the waiting list size (on incomplete 18 week RTT pathways) since January 2013:

	In-Patients	Out-Patients	Grand Total	% Incompletes < 18 weeks	% Incompletes Outpatient
2013					
Jan	5922	14241	20163	96.01%	70.63%
Feb	5848	14480	20328	95.44%	71.23%
Mar	5558	14865	20423	95.24%	72.79%
Apr	5631	16839	22470	95.65%	74.94%
May	5682	17213	22895	96.36%	75.18%
Jun	5782	23652	29434	93.27%	80.36%
Jul	5620	23907	29527	92.89%	80.97%
August	5544	25266	30810	92.21%	82.01%
Sep	5497	25248	30745	92.58%	82.12%
Oct	5394	24695	30089	93.87%	82.07%
Nov	5548	23785	29333	93.88%	81.09%
Dec	5648	24795	30443	93.07%	81.45%
2014					
Jan	5699	23145	28844	92.90%	80.24%
Feb	5613	23765	29378	93.02%	80.89%
Mar	5631	25078	30709	92.74%	81.66%
Apr	5574	25066	30640	92.67%	81.81%

There are 2 major changes that affected list size:

- ***June 2013:*** the Trust adjusted its reporting following the audit work that had been undertaken to ensure that all follow up outpatients on an open 18 week pathway were reported
- ***October 2013:*** all pathways were reported, including the patients in the cohort undergoing retrospective analysis.

Appendix 2: Revised Performance Trajectories by Specialty

Table 1.1: Admitted pathways 2014/15: % under 18 weeks (highlighted areas are below the target)

	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cardiology	89.2%	90.0%	90.0%	90.0%	90.4%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Gastro	98.1%	97.5%	97.5%	97.5%	97.5%	97.5%	97.5%	97.5%	97.5%	97.5%	97.5%
Resp. Med.	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%
Gen Surg.	90.1%	90.1%	90.7%	90.7%	90.0%	90.0%	90.6%	93.8%	93.3%	93.3%	93.3%
Urology	90.9%	93.6%	90.0%	90.0%	90.5%	92.5%	92.5%	92.5%	92.5%	92.5%	92.5%
T&O	64.3%	64.3%	64.3%	64.3%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Plastics	88.9%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%
ENT	88.0%	90.4%	90.0%	90.0%	90.5%	90.4%	90.5%	90.5%	90.5%	90.5%	90.5%
Ophthamology	81.0%	84.9%	93.0%	92.3%	93.1%	92.8%	90.4%	90.4%	90.4%	90.4%	90.4%
Oral	86.8%	77.6%	85.3%	90.0%	86.1%	86.7%	86.7%	86.7%			

Table 1.2: Non-Admitted pathways 2014/15: % under 18 weeks (highlighted areas are below the target)

	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cardiology	90.8%	90.8%	90.2%	90.2%	96.3%	97.9%	95.5%	95.5%	95.5%	95.5%	95.5%
Gastro	97.2%	97.0%	97.0%	97.0%	97.0%	97.0%	97.0%	97.0%	97.0%	97.0%	97.0%
Resp. Med.	95.5%	95.5%	95.5%	95.5%	95.5%	95.5%	95.5%	95.5%	95.5%	95.5%	95.5%
Gen Surg.	98.3%	96.2%	96.9%	97.5%	97.5%	97.5%	97.5%	97.5%	97.5%	97.5%	97.5%
Urology	95.2%	95.3%	95.3%	95.3%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
T&O	94.3%	94.3%	95.7%	95.7%	95.7%	95.7%	95.7%	95.7%	95.7%	95.7%	95.7%
Plastics	94.5%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
ENT	95.1%	95.1%	95.1%	95.0%	95.0%	95.0%	95.5%	95.5%	95.5%	95.5%	95.5%
Ophthalmology	98.0%	97.6%	97.7%	97.8%	97.7%	97.9%	95.5%	95.5%	95.5%	95.5%	95.5%
Oral	96.8%	95.3%	95.8%	95.4%	95.6%	95.0%	95.0%	95.0%			

Table 4: Incomplete pathways 2014/15: % under 18 weeks (highlighted areas are below the target)

	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cardiology	78.3%	81.1%	84.4%	85.2%	86.1%	93.0%	92.5%	92.1%	92.6%	92.3%	92.7%
Gastro	96.1%	96.3%	96.3%	96.3%	96.3%	96.3%	96.3%	96.3%	96.3%	96.3%	96.3%
Resp. Med.	92.0%	92.0%	92.5%	92.3%	92.4%	93.1%	93.9%	93.9%	94.0%	94.0%	94.0%
Gen Surg.	95.2%	94.1%	94.7%	95.0%	94.9%	94.9%	95.1%	96.2%	93.8%	93.8%	93.8%
Urology	93.1%	94.6%	93.1%	92.9%	92.8%	93.8%	93.8%	93.8%	93.4%	93.4%	93.4%
T&O	84.3%	84.3%	85.2%	85.2%	93.8%	93.8%	93.8%	93.8%	93.2%	93.0%	93.0%
Plastics	92.0%	92.0%	92.1%	92.0%	92.0%	92.0%	92.1%	92.4%	92.3%	92.1%	92.1%
ENT	90.0%	94.2%	94.2%	94.2%	94.3%	94.1%	98.0%	98.0%	98.0%	98.0%	98.0%
Ophthalmology	94.1%	92.8%	95.9%	95.8%	95.9%	96.0%	93.7%	93.7%	93.7%	93.7%	93.7%
Oral	86.1%	88.8%	90.5%	92.0%	91.9%	93.1%	93.1%	93.1%			

Appendix 3: Original Waiting list projection compared with revised activity trajectory by speciality

	April	May	June	July	August	September	October
Gen Surg.	1848	1878	1893	1820	1757	1734	1736
GS revised profile (April Actual)	1941	1878	1893	1838	1793	1788	1808
Variance to orig profile	93	0	0	18	36	54	72
Urology	1465	1398	1400	1364	1307	1278	1294
Urology revised profile (April Actual)	1215	1398	1449	1378	1334	1318	1348
Variance to orig profile	-250	0	49	14	27	40	54
T&O	3360	3266	3172	3047	3455	3347	3242
T&O revised profile (April Actual)	2819	3313	3221	3128	3597	3544	3492
Variance to orig profile	-541	47	48	81	142	197	250
ENT	2082	2173	2269	2384	2441	2511	2462
ENT revised profile (April Actual)	1916	1840	1912	2022	2156	2231	2309
Variance to orig profile	-166	-333	-357	-362	-285	-280	-153
Ophthalmology	5235	5186	5208	5208	5208	5208	5208
Ophthalmology revised profile (April Actual)	5937	3866`	4153	4222	4459	4282	4224
Variance to orig profile	702	-1320	-1055	-986	-749	-926	-984
Cardiology **Nb** Plan to be reviewed pending completion of validation in June	2187	2333	2286	2199	2152	2095	1985

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Risk Register Update
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Mariola Smallman, Head of Risk Management
DATE OF MEETING:	5 June 2014

EXECUTIVE SUMMARY:

The Trust Risk Register compromises high (red) risks that have been through the validation processes at directorate / group and Executive Committee levels.

The Clinical Leadership Executive is responsible for reviewing and approving high (red) risks validated by Risk Management Committee, which are proposed for inclusion on the Trust Risk Register reported to Trust Board.

The Trust Risk Register was reported to the Board at its May meeting. As at writing there is one notification of a downgrade and four proposed additional risks. These and the existing risks are at **Appendix A**: Trust Risk Register.

High (red) risks that have been reviewed by the Risk Management Committee and continue to be managed at Clinical Group, Corporate Directorate or Project levels are provided as a Summary Risk Log at **Appendix B.** The Summary Risk Log is reported to CLE and Trust Board to ensure oversight at each relevant executive committee.

REPORT RECOMMENDATION:

1. **DISCUSS** the proposed high (red) risks and **AGREE** if they are to be added to the Trust Risk Register.
2. **AGREE** downgrading of the Pathology risk related to the unpredicted downtime on the archival/retrieval unit to a medium (amber) level risk, with continued management at Group level and monitoring by the RMC.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	✓	✓

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply)*:

Financial	✓	Environmental	✓	Communications & Media	
Business and market share		Legal & Policy	✓	Patient Experience	✓
Clinical	✓	Equality and Diversity	✓	Workforce	✓

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Aligned to BAF, quality and safety agenda and requirement for risk register process as part of external accreditation programmes.

PREVIOUS CONSIDERATION:

The Board receives regular risk register updates.

FOR DECISION

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Risk Register

Report to the Trust Board on 5 June 2014

1. EXECUTIVE SUMMARY

1.1 The Trust Risk Register compromises high (red) risks that have been through the validation processes at directorate / group and Executive Committee levels.

1.2 The Risk Management Committee (RMC) is responsible for overseeing the development of risk registers across the Trust utilising a consistent methodology and standardised format. Review of high (red) risks by RMC provides a trust-wide validation stage to ensure consistency, identify duplicates and interdependencies.

1.3 The Clinical Leadership Executive is responsible for reviewing and approving high (red) risks validated by Risk Management Committee, which are proposed for inclusion on the Trust Risk Register reported to Trust Board.

1.4 Management of individual risks continues at each level of risk register they feature; escalation of risks through management reporting structures does not transfer all ownership of the risk.

1.5 Updates to the existing risks on the Trust Risk Register and the proposed additions were received by CLE at its meeting on 27 May 2014. Following discussion, it was agreed to escalate four risks to the Board for consideration. As a reminder, the options available for handling these risks are:

Terminate	Cease doing the activity likely to generate the risk
Treat	Reduce the probability or severity of the risk by putting appropriate controls in place
Tolerate	Accept the risk or tolerate the residual risk once treatments have been applied
Transfer	Redefine the responsibility for managing the risk e.g. by contracting out a particular activity.

2. Trust Risk Register Update

2.1 The Trust Risk Register was reported to the Board at its May meeting. As at writing there is one notification of a downgrade (see 2.1.1), an update to the Workforce Delivery Plan risk and four proposed additions:

2.1.1 The Pathology Group Director has confirmed the risk related to "Unpredicted downtime on archival/retrieval unit", has been downgraded to medium (amber) and will continue to be managed by the Group. Productive discussions with the Company together with robust contingency measures should the system go down again are the key reasons for the downgrade in the risk.

2.1.2 One Ophthalmology risk relating to privacy and dignity at Sandwell Outpatients.

2.1.3 Two Women's and Child Health risks related to a lack of paediatric tier four beds and paediatric HDU staffing.

2.1.4 One Medicine risk related to acute oncology standards not being fully met.

The risks mentioned above set out in **Appendix A**: Trust Risk Register.

2.2 High (red) risks that have been reviewed by the Risk Management Committee and continue to be managed at Clinical Group, Corporate Directorate or Project levels are provided as a Summary Risk Log at **Appendix B.** The Summary Risk Log is reported to CLE and Trust Board to ensure oversight at each relevant committee.

2.3 The RMC will review and report High (red) risks to CLE on a monthly basis and highlight new risks or changes to existing risks. The CLE will update the Board on existing risks and escalate 'new' risks.

3. RECOMMENDATION(S)

The Board is recommended to:

3.1 **DISCUSS** the proposed high (red) risks and **AGREE** if they are to be added to the Trust Risk Register.

3.2 **AGREE** downgrading of the Pathology risk related to the unpredicted downtime on the archival/retrieval unit to a medium (amber) level risk, with continued management at Group level and monitoring by the RMC.

Kam Dhami
Director of Governance
29 May 2014

Appendix A

Trust Risk Register (version as at 29 May 2014)

High (Red) Risk Summary Log

APPENDIX 1, SECTION A

Reference Number	Source of Risk	Corporate Directorate / Clinical Group / Corporate Project	Specialty / Ward / Team	Risk Category	Risk	Likelihood	Severity	Risk Rating (LxS)	Summary of Risk Controls and Treatment Plan	Lead Director	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
1401MMH001	Project Risk Assessment	MMH Project Board		Organisational (Strategic)	Increase in cost of Midland Metropolitan Hospital if approval delayed, then restarts approval cycle.	4	5	20	Involvement of Chair and Chief Executive with Department of Health and HM Treasury officials.	Director of Estates and New Hospital Project	Oct-18	May-14	Quarterly	3	5	15
1414MARWK03		Chief Executive	Workforce Strategy	Organisational (Strat	Insufficient policy levers to ensure effective delivery of Trust workforce plan establishment reduction of 1300 wte's, leading to excess pay costs.	4	5	20	Review of existing policy levers to ensure options are maximised and are executed sufficiently early. Strong governance oversight by the Trust Board. **Update:** Plan to finalise a more detailed plan being developed through the CLE Workforce Committee, led personally by the Chief Executive. Will culminate in review at the Board's Workforce and OD Committee in September 2014.	Chief Executive pending appointment of Director of OD.	Mar-20	May-14	bi-monthly	3	5	15
2013HASU01	CCG	Medicine	Stroke/Admitted Care	Operational/Business	Potential loss of the Hyper Acute Stroke Unit which is subject to an external commissioner led review.	4	4	16	Trust representatives on Strategic Review sub groups; SWBH Stroke Action Team continues to monitor stroke activity and performance on a monthly basis and to develop actions plans for service improvement; Implement action plans to improve data capture and accuracy.	Clinical Group Director Medicine	TBC - Commissioner led review	Feb-14	Monthly	4	3	12
14-01-PATH-36	Incidents	Pathology	Pathology/Microbiology/Clinical Biochemistry	Operational/Business	Unpredicted downtime on archival/retrieval unit due to equipment failure. Patient management could be compromised/delayed due to a repeat sample being required.	4	4	16	Working with archive machine supplier to resolve issue. Contingency measures in place involving manual archiving. See Appendix A, Section B. **Update:** Confirmation received from the Pathology Group Director that the risk has locally been downgraded to medium (Amber) and will continue to be managed by the Group. The risk has been downgraded because the track system has been the subject of several high level meetings between Pathology staff and the Company, including their automation experts spending time in our laboratory. They have discovered a number of issues with the way our system was set up by the Company that are being addressed. This, together with robust contingency measures should the system go down again are the key reasons for the downgrade of the risk.	Clinical Group Director Pathology		Mar-14	Monthly	3	3	9
TRR1401COO01	Management review	Corporate Operations		Operational	Lack of assurance of standard process and data quality approach to 18 weeks.	4	4	16	Task and Finish Group established to oversee rapid improvement programme; SOP to be agreed and implemented in March for new processes; Elective access team structure to be reviewed; Central booking process to be strengthened to ensure real time data quality management; IST visit will inform work programme content.	Chief Operating Officer	Jul-14	Jan-14	Jul-14	2	4	8

Reference Number	Source of Risk	Corporate Directorate / Clinical Group / Corporate Project	Specialty / Ward / Team	Risk Category	Risk	Likelihood	Severity	Risk Rating (LxS)	Summary of Risk Controls and Treatment Plan	Lead Director	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
TRR1401COO02	Management review	Corporate Operations		Operational	Sustained high Delayed Transfers of Care (DTOC) patients remaining in acute bed capacity.	4	4	16	Joint working through joint discharge teams on both acute sites established; 7 day working pilot; Weekly urgent care call with Chief Executives and Chief accountable officers from LAT, CCG, NTDA, acute Trust and social services includes weekly DTOC review and strategic and operational work; Commissioning plans for 7 day working in 2014 in train.	Chief Operating Officer	Jun-14	Jan-14	Jul-14	2	4	8
PROPOSED ADDITIONS																
0907SOP15	Inspections: H&S and PEAT	Surgery B	Opthalmology	Clinical	Risk of Breech of Privacy and Dignity Standard, Information Governance Risk and Infection Control Risk at Sandwell Outpatient Department Risk that either a patient's health or privacy/dignity will be compromised as a consequence of poor building design in Sandwell Ophthalmology OPD. Clean/dirty utility failings cannot be addressed without re-development of the area.	5	4	20	Trust Solution fitting in with RCRH required, Compliance with Medical Device and ICOC standards, Service Improvement application to Sandwell OPD, Greater use of Rowley facilities	Director of Estates and New Hospital Project	31/12/2015	11/03/2014	GBM	5	4	20
1103PAE02	Risk Assessment	Womens and Child Health	Padiatrics	Clinical	Children requiring HDU 1:1 care may not receive - due to unpredictable demand, inadequate funding, poor staffing levels. Quality of care compromised for these and non HDU children due to inadequate staffing levels	4	4	16	IAP submitted for HDU funds secured 12-13 to staff areas. Additional IAP submitted 13-14 for Paediatric Outreach team. Awaiting outcome from November IAP submission.	Chief Operating Officer	TBC	Mar-14	Monthly	4	4	16
1103PAN01	Risk Assessment	Womens and Child Health	Padiatrics	Clinical	Lack of Tier 4 beds for C&YP with Mental Health problems means that they are admitted to the paediatric ward. There is no specialist medical or nursing mental health team to care for their needs with limited access to in / out of hours CAMHS support. Care for these children is compromised and impacts also on other children and parents.	4	4	16	Bank and agency staff utilised where available. Incidents to be escalated to the Health Forum / SSCB / PAB LA. Monthly report to be developed and reviewed at Paediatric Governance meeting and information provided to risk, Health Forum / SSCB / PAB. Honorary contracts for psychiatrists to be explored.	Chief Operating Officer	TBC	Mar-14	Monthly	4	4	16

Reference Number	Source of Risk	Corporate Directorate / Clinical Group / Corporate Project	Specialty / Ward / Team	Risk Category	Risk	Likelihood	Severity	Risk Rating (LxS)	Summary of Risk Controls and Treatment Plan	Lead Director	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
	Oncology Peer Review	Medicine	Scheduled Care	Operational	The external peer review stated the Trust does not meet Acute Oncology Service (AOS) clinical standards. The risks associated with service concern a deficiency of medical staff availability to support the service due to retirement and sickness absence. Furthermore the current cancer service provision exceeds the SLA, with there being no AOS five day medical cover on either site to ensure patients are reviewed within 24hrs. There are no fast track clinics for ED referrals which gives rise to increased admissions. There is no capacity to backfill specialised nurses when staff take leave, sickness or other no-notice leave. The Chemotherapy Pharmacist is currently on extended leave therefore there is no service.	5	4	20	Current AOS mitigation measures are not sustainable. IAP submitted. Locum appointed to commence April 2014 to cover the consultant oncologist retirement and to provide some elements for the AOS peer review recommendations. SLA review /revision in progress. Options appraisal developed as part of IAP to inform the way forward for the service. Local Trusts have been approached for Pharmacy Staff Grade cover, however there is currently no cover available. The templates are currently being revised by the Service Manager and a plan is in place to obtain Locum cover.	Medical Director	TBC	May-14	Monthly	5	4	20

Number	Ref	Summary of Risk	Probability	Severity	Risk Rating (PxS)	Lead Director responsible for risk treatment plan	Group / Directorate	Expected date of completion	Source of internal review	Frequency of Review	Probability	Severity	Residual risk rating	↑ ↓
Risk category: CLINICAL														
1	201207Mat01	Failure to follow up antenatal screening results (Downs) could result in women being denied screening and/or appropriate action being taken which could subsequently lead to a baby born with congenital abnormalities. Increased risk of mortality or morbidity.	3	5	15	Womens and Child Health Group Director	Maternity and Perinatal Medicine	2014/15	WCH Group Management	Monthly	2	5	10	
Risk category: FINANCIAL														
2		Failure to develop robust 3 year outline CIP plans as part of the FT application (16/17, 17/18, 18/19)	4	4	16	Director of Finance	Finance	2014/15	FT Project	Monthly	3	3	9	
3		Failure to develop robust rolling 2 year detailed CIP plans as part of the FT application (14/15 & 15/16)	4	5	20	Director of Finance	Finance	2014/15	FT Project	Monthly	3	4	12	
4	1402FIN03	Loss of WEBDE on 31st August 2014 will disrupt payroll processing.	5	4	20	Director of Finance	Payroll	2014/15	Finance Management	Monthly	3	2	6	
Risk category: NON-CLINICAL / ENVIRONMENTAL														
5	14-03-PATH-03	Extremely noisy / cramped laboratories (Trace Elements laboratory and Vitamins laboratory) not considered a safe working environment for staff.	5	3	15	Pathology Group Director	Biochemistry	2014/15	Pathology Management	Monthly	2	3	6	
6	201302OBS01	Risk of Baby abduction - the current baby tagging system is not fit for purpose.	3	5	15	Womens and Child Health Group Director	Maternity and Perinatal Medicine	2014/15	WCH Group Management	Monthly	2	5	10	
Risk category: OPERATIONAL														
7		The validity and reliability of reports produced for management of the Trust key activities are bespoke, variable and lack controls on release. This results in variability in multiple reports and potential data quality issues.	4	4	16	Chief Operating Officer	COO	2014/15	COO	Monthly	2	4	8	
8	1414MARWK	High levels of staff turnover in localised areas impeding the development of coherent high performing teams and consequent adverse impact on the safe delivery care.	5	4	20	Medicine Group Director / Workforce Directorate Lead	HR Manager from Medicine and Medicine Group Leadership	2014/15	Workforce & Organisational Development Assurance Committee	Monthly	3	4	12	
9	14-03-PATH-02	Insufficient staff over the long term in the TPMT and Vitamins labs which is adversely impacting on both operational service delivery and the workforce.	5	3	15	Pathology Group Director	Biochemistry	2014/15	Pathology Management	Monthly	2	3	6	
10	13-12-PATH-30	Blood Sciences and Blood Transfusion Blood Testing Services at City and Sandwell Hospitals turnaround times are not always met due to inadequate staffing levels.	4	4	16	Pathology Group Director	Blood Sciences	2014/15	Pathology Management	Monthly	2	2	4	
11	0314SB03	Business risk due to lack of appropriate Levels of management support for Group B. Currently only GDO and GM to support all of Group B, this is exacerbated during periods of planned and unplanned leave	5	3	15	Surgery B Group Director	Ophthalmology	2014/15	Group B Management	Monthly	2	3	6	

Number	Ref	Summary of Risk	Probability	Severity	Risk Rating (PxS)	Lead Director responsible for risk treatment plan	Group / Directorate	Expected date of completion	Source of internal review	Frequency of Review	Probability	Severity	Residual risk rating	↑ ↓
12	0314SB01	Business (IG) risk due to possible loss of data. Data storage capacity for ophthalmic imaging has been exceeded; data stored locally on some machines contavening IG Standards; OCT equipment no longer able to function.	5	4	20	Surgery B Group Director	Ophthalmology	2014/15	Group B Management	Monthly	2	2	4	
13	201309NEO01	High vacancy rates in the neonatal unit and non compliance to BAPM standards for nursing staff - potential compromise to care in times of high activity.	4	5	20	Womens and Child Health Group Director	Obstetrics and Neonates	2014/15	WCH Group Management	Monthly	2	3	6	
14	1209WKF02	High levels of sickness absence adversely affecting the development of high performing cohesive teams supporting the delivery of high quality care.	5	3	15	Workforce	Workforce	2014/15	Workforce & Organisational Development Assurance Committee	Monthly	3	3	9	
Risk category: ORGANISATIONAL / STRATEGIC														
15	201403FTP2	Inability to achieve external validation of QGAF / BGAF standards would adversely affect the FT application.	3	5	15	Director of Governance	Director of Governance	2014/15	FT Project	Monthly	2	5	10	
16	201403FTP3	Organisation is unable to design and implement arrangements for the body of the organisation to be well-led which undermines FT process.	4	5	20	CEO / Director of OD when appointed	Director of OD	2014/15	FT Project	Monthly	2	5	10	
17	201403STRBD1	Failure to achieve a successful outcome from prospective tender processes resulting in a loss of income /reputation as a result of lack of capacity, skills and capability to respond successfully to procurement opportunities for existing and new services.	4	4	16	CEO / Director of OD when appointed	Strategy	2014/15	Strategy Management	Monthly	3	4	12	
18	201403STRBD4	The Practice Support/BD team fail to maintain relationships with Practices, CCG's and other Primary Care Services both to identify intelligence as well as to preserve and maintain relationships with the Trust	4	4	16	CEO / Director of OD when appointed	Strategy	2014/15	Strategy Management	Monthly	2	4	8	
19	201403FTP1	Failure to achieve FT status within TDA agreed timescales as a result of inability to meet the requirements of the assessment process.	5	4	20	Director of Finance	Finance	2014/15	FT Project	Monthly	3	4	12	
20		Inability to comply with the PAF framework, Monitor Compliance Framework and NHS Performance Assessment Framework leading to adverse knock-on impact on reported progress within the TFA.	5	4	20	Director of Finance	Finance	2014/15	FT Project	Monthly	3	4	12	
21		Sustain the opportunities to Income Generate: Failure to reach projected contract numbers or perform to the contractual obligations of our Funding Broker could result in the loss of income generation funding that supports apprenticeships development and also funds other wider Trust development activities from any under spend available.	5	3	15	Workforce	L&D	2014/15	Workforce & Organisational Development Assurance Committee	Quarterly	1	5	5	

Sandwell and West Birmingham Hospitals NHS

NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Update on achievement of red & amber-rated actions in the 2013/14 annual plan
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite – Director of Finance & Performance Management
AUTHOR:	Neetu Sharma – Head of Strategic Planning
DATE OF MEETING:	5 June 2014

EXECUTIVE SUMMARY:

The Board was presented with the final status of the 13-14 annual plan at May's Trust Board meeting (01.05.14). A series of red and amber-rated actions were highlighted as those which had not been completed by the end of Q4.

The purpose of this paper is to identify whether these actions remain a priority for 14/15 and, if so, to provide assurance that these actions are now being addressed and tracked elsewhere.

The table included at section 2 outlines the following:

- Actions 1-18 are considered to be a priority for 2014-15.
- Actions 19-27 are actions which have either been completed, or no longer remain a priority for this year.

REPORT RECOMMENDATION:

It is recommended that the Board reviews these actions and that the 13-14 plan is considered 'closed'.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	x	Environmental	x	Communications & Media	x
Business and market share	x	Legal & Policy	x	Patient Experience	x
Clinical	x	Equality and Diversity	x	Workforce	x

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Relates to all annual priorities

PREVIOUS CONSIDERATION:

May 2014 (Q4 update)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

UPDATE ON ACHIEVEMENT OF RED & AMBER-RATED OBJECTIVES IN THE 2013/14 ANNUAL PLAN

Report to Trust Board on 5th June 2014

1 EXECUTIVE SUMMARY

1.1 Trust Board was presented with a final status report on the objectives within the 13/14 annual plan at its meeting on 1st May 2014.

There were 27 objectives noted as not completed during 13/14.

1.2 The purpose of this paper is to recommend which of these objectives are appropriately priorities for 14/15 and to provide assurance that the actions related to those priority objectives are clear and being tracked for delivery.

2 RED & AMBER-RATED OBJECTIVES

2.1 The table below includes all of the remaining 'incomplete' objectives from the 13/14 annual plan.

2.2 Where the objective remains a priority for 14/15, detail is provided around the key actions required to complete the objective, as well as the reporting structure that monitors delivery.

2.3 Where the objective is not deemed a priority for 14/15, a brief description is included as to why this is the case (e.g. action is now complete/objective superseded).

Ref	13/14 objective	Exec lead	Priority for 14/15?	Actions to progress in 14/15	Assurance/tracking	Deadline
1	Attain 10% better than the national mean for sickness absence rates	DSOD	✓	• Group Directors to develop local action plans to address their adverse sickness absence performance • Workforce directorate scoping viability of electronic system for sickness absence case management • Project plan will be shared with the Workforce Delivery Committee in July 2014	• Workforce Delivery Committee • Monthly Integrated Performance Report • Workforce Plan 2014-2017 (TT)	March 2015
2	Implementation of revised appraisal system including skills development & objective-setting training programme	DSOD	✓	• Scope and direction for revised appraisal process reconsidered & agreed at Exec Group (13.5.14) • Approach discussed in more detail and agreed with group and corporate representatives at Workforce Delivery Committee (15.5.14) • Appraisal system to be designed – including policy – by 1.7.14 • Pilot in two areas after 1.7.14 (clinical area + facilities)	• Workforce Delivery Committee • Workforce Plan 2014-2017 (TT)	July 2014
3	Your Voice: development of focused action plans in response to 'Hot Spot' areas.	DSOD	✓	• Only 50% of group action plans have been developed. Further engagement from groups required. • Groups are being chased for action plans • Trust average for changes made is only 10% awareness & awareness of the results is just over 20% and improving	• Workforce Delivery Committee	On-going
4	Submit FT application in line with revised TFA milestones	DF	✓	• No formal timeline agreed with TDA • TDA/CQC to confirm date of CIH visit which is key milestone in FT application • CIH visit estimated in Q3 (2014/15) • Project plan has been drawn up based on either May 15 or May 16 submission of application to Monitor • IBP & LTFM will be submitted to TDA on 20.06.14 • FT Development Committee engaging with clinical and corporate groups ahead of the CIH visit.	• FT Programme Team • FT Development Committee • Monthly report to Trust Board (FT Programme Director Report)	May 2015 / May 2016

Ref	13/14 objective	Exec lead	Priority for 14/15?	Actions to progress in 14/15	Assurance/tracking	Deadline
5	Compliance with all QGAF domains	DG	✓	• Revised FT timetable in development which will inform the specific requirements for completion of the QGAF formal self-assessment and external validation process. • Timetable anticipates that QGAF external assessment will take place in September 2014, with evidence compilation beginning in June 2014, and Board self-assessments in July (Trust Board Informal Session)	• FT Programme Team	September 2014
6	Make progress with MMH	DE	✓	• TDA Board approved MMH financial model • DH and HMT approval to come • Respond promptly to queries • OJEU scheduled for end of June 2014 • Selection of 3 bidders (June – Sept 2014)	• MMH Core Team • Configuration Committee	On-going
7	Implement redesigned care pathways and other QIPP schemes	COO	✓	• The 2013/14 QIPP values were held at a high level within the price/activity matrix. • In the 2014-15 Heads of Agreement commissioners have identified a number of areas where changes need to be made to improve services and deliver QIPP savings in the next contractual year. These include but are not limited to improved patient management to reduce outpatient review attendances in medical specialties. In particular the following specialties have been highlighted: ➢ Cardiology ➢ Paediatrics ➢ Dermatology ➢ Geriatric medicine ➢ Rheumatology ➢ Gastroenterology ➢ General medicine	• Configuration Committee	March 2015

Ref	13/14 objective	Exec lead	Priority for 14/15?	Actions to progress in 14/15	Assurance/tracking	Deadline
8	Implement a virtual ward in the community	COO	✓	• PCAT implemented and referrals managed via virtual ward to avoid unnecessary admissions. Project extended to end June 14. CCG commissioner preparing report, with SWBH, for on-going funding. • PCAT avoided 218 admissions within first 16 weeks of pilot either returning patients home (153) or stepping up to a community bed (65). • Integration of ICARES & DNs to deliver integrated community nursing specification. Standard operating procedures agreed at locality level with GPs. KPIs being agreed with SWBH & CCG (TBC June 14). • Pilot agreed with CCG clinical leads to further integrate ICARES, DNS and Social Care around primary care push sites, using the Better Care Fund. Start date Oct 14. Social care and community staff to be co-located.	• Monthly meetings with GP lead for cluster.	October 2014
9	Enable clinically-led decision making processes via SLR	MD	✓	• Software purchased after user consultation exercise, currently in review and testing phase with trust data populated and reporting structure being defined and error proofed • Service Lines aligned around Trusts directorate taxonomy where possible. • Roll out for directorate triumvirates currently being planned after first testing and feedback session with Women and Children's. • To be used in parallel with standard reporting process in 14/5.	• SLR Technical Group (chaired by the Associate Medical Director – Innovation)	September 2014
10	Develop strategic outline case for the EPR replacement	CII	✓	• Subject to Board approval the Trust will enter into a pre-due diligence process with CSC to qualify the current offer from DH and CSC that is available to the	• HIS Senior Management Team (weekly)	August 2014

Ref	13/14 objective	Exec lead	Priority for 14/15?	Actions to progress in 14/15	Assurance/tracking	Deadline
				North (NE and NW) Midlands (West and East) and East of England. This exercise is expected to commence in July and complete in August.		
11	Upgrade to data centre	CII	✓	• The relocation of the City telecommunications exchange and data centre was profiled into the capital plan for 2014/15. • An options appraisal is underway to look at locations within the retained estate at both City and Sandwell.	• HIS Senior Management Team (weekly)	March 2015
12	Replacement of chemotherapy prescribing system	CII	✓	• First phase of the ChemoCare deployment has been completed and is live • EPR continue to implement ChemoCare by at a speciality level, focusing on a number of specialties every 2-3 months.	• Cancer Services managing phased implementation	Dec 2015
13	Conduct digital dictation pilot	COO	✓	• This scheme was profiled from the 1314 scheme to 1415 as a result of the procurement of the VitalPACS digital surveillance scheme. • This project is now included in the Year of Outpatients Programme. • Agreed that digital dictation will be purchased with voice recognition – must be implemented within 6 months • Group Director of Ops will be responsible for steering the project with identified leads and a clear project structure at each stage	• Year of Outpatients Programme Board (fortnightly) • Weekly YOOP delivery group	November 2014
14	Attain national mean for emergency re-admissions	COO	✓	• Change team developing a dashboard for readmissions • Meeting to agree the metrics for the dashboard • This will be vehicle for measuring readmissions at a more detailed level, and will contain targets to measure outcomes of work programme	• Readmissions Taskforce (chaired by Medical Director)	September 2014

Ref	13/14 objective	Exec lead	Priority for 14/15?	Actions to progress in 14/15	Assurance/tracking	Deadline
15	Improvements to the way we provide care for emergency and acutely unwell patients / consistently achieve national A&E targets	COO	✓	• Extensive redesign of urgent care pathways was undertaken throughout 2013/14. In addition there was work done around timely and effective patient discharge (which included the establishment of 2 wards for patients who were Medically Fit for Discharge and further integration between health and social care teams). This work will be reviewed and refined over the course of the year. In addition, extensive remodelling of capacity management will be undertaken following the introduction of systems using the Electronic Bed Management System • Performance against the national ED targets improved and the Trust achieved the targets required by the 4 hour standard in month 12 of 13/14 and Month 1 of 14/15. Performance in May has dropped below this and there will be a renewed focus upon measure to improve and sustain the required level of performance	• Performance against emergency access targets is monitored at Specialty and Clinical Group level while corporately there is scrutiny of these at OMC	October 2014
16	Waiting times in at least 90% of specialities will be as good as neighbours	COO	✓	• The Trust maintains its focus on achieving the national standards throughout 2014/15. Specialties experiencing difficulty in achieving the 18 week RTT targets have submitted recovery plans with trajectories for improvement. Clinical Groups will be managed against these during the year • Local benchmarking against the performance of other Trusts remains to be implemented	• Performance against the waiting list targets is monitored at the Clinical Group waiting list meetings, the Trust weekly waiting list meeting and there is scrutiny of performance at OMC	October 2014
17	Develop alternative models of face to face contact including Digital First	COO	✓	• Non-face to face contact to be developed – greater use of telephone calls, virtual visiting, increased advice & guidance, ensuring patients have access to SOS line of communication, increased use of skype	• Picked up through action plans developed for each of the newly established C&T directorates	March 2015

Ref	13/14 objective	Exec lead	Priority for 14/15?	Actions to progress in 14/15	Assurance/tracking	Deadline
				consultation sessions. Particular importance for patients with long term conditions.		
18	Develop a new service model for Frail Elderly	COO	✓	• Combined JDs for geriatric and acute medicine (to provide older adult consultant leadership) have been approved by the Royal College. • One post has been filled, and interviews are being held in June 2014 for second post. • Action plan developed - awaiting COO sign off.	• Reported weekly through the Urgent Care Performance Board	March 2015
19	Reduce rate of written complaints per 1000 episodes by 5% / reduce link complaints	DG	x	• Priority has been reframed. 14-15 focus is for complaints to be responded to within set time limits.		
20	Review of PALS function and resources	DG	x	• Review of PALS function being undertaken nationally – awaiting outcome of this review before reviewing PALS function and resources internally.		
21	Develop further five 5 year clinical strategies at speciality or condition level	DSOD	x	• Clinical group strategies to be developed as part of 2020 plan. Work to begin at Leadership Conference on 3rd June 2014. Group strategies will inform 2020 plan, which will submitted to TDA in form of 'Trust Clinical Strategy' in August/September 2014.		
22	Undertake external assurance review of estates compliance outcomes 10 & 11	DE	x	• External assurance review report completed and issued May 2014.		
23	Develop comprehensive marketing plans for at least 3 of our services	DSOD	x	• Marketing plans will now be developed by clinical groups.		
24	Procure Business Intelligence system	CII	x	• Funding was utilised for the procurement of the Service Line Reporting Solution, this is now implemented.		

Ref	13/14 objective	Exec lead	Priority for 14/15?	Actions to progress in 14/15	Assurance/tracking	Deadline
25	Unified Communications pilot	CII	x	• This project was re-profiled from the capital scheme in 13/14 to accommodate the procurement of Vital PAC solution and was initially carried forward to 14/15. A revision to the 14/15 capital programme has placed this scheme as a priority 2 from the reserve allocation.		
26	Innovative wireless communication systems for emergency department MDT	COO	x	• Leadership & role development obviates requirement for technology based solution.		
27	Establish a base line of current usage of intra-operative goal fluid therapy & explore potential for expansion of use through mapping of HRGs	MD	x	• Baseline audit completed and usage has expanded across the trust (based on theatre stock levels). • This was included in 13-14 plan as a pre-qualification for CQUIN.		

3 RECOMMENDATION

3.1 That the Board challenge and confirm those objectives which are appropriately priorities for 14/15

3.2 That the 13/14 plan is considered closed.

Tony Waite
Director of Finance & Performance Management
28th May 2014

Sandwell and West Birmingham Hospitals NHS

NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Timetable to sign off five year plan Submissions due on June 20TH 2014
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite – Director of Finance & Performance Management
AUTHOR:	Neetu Sharma – Head of Strategic Planning
DATE OF MEETING:	5 June 2014

EXECUTIVE SUMMARY:

The Trust is required to make a sequence of planning submissions to the Trust Development Authority (TDA) as stipulated in their Planning & Technical Guidance 14/15 (published December 2013). The final submission is to be made on Friday 20th June 2014, and comprises:

- Five year plan summary
- Five year workforce plan
- Five year activity plan
- Integrated Business Plan (IBP)
- Long Term Financial Model (LTFM)

This paper provides an update on the current status of these documents, and the previous consideration they have received at Board level. Each of the items listed above will be signed off by the Chief Executive and Director of Finance and Performance Management before the submission is made to the TDA.

REPORT RECOMMENDATION:

The Board is asked to note the submission requirements for the TDA planning return (20th June 2014).

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	x	Environmental	x	Communications & Media	x
Business and market share	x	Legal & Policy	x	Patient Experience	x
Clinical	x	Equality and Diversity	x	Workforce	x

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Alignment to all Trust objectives, Trust risk register and LTFM

PREVIOUS CONSIDERATION:

TDA planning submissions previously discussed at 6 March 2014 & 3 April 2014 Trust Board meetings

Sandwell and West Birmingham Hospitals
NHS Trust

TIMETABLE TO SIGN OFF FIVE YEAR PLAN SUBMISSIONS DUE ON JUNE 20TH 2014

Report to Trust Board on 5th June 2014

1 EXECUTIVE SUMMARY

1.1 The Trust is required to make a sequence of planning submissions to the Trust Development Authority (TDA) as stipulated in their Planning & Technical Guidance 14/15 (published December 2013). The final submission is to be made on Friday 20th June 2014, and comprises:

- Five year plan summary (draft)
- Five year workforce plan
- Five year activity plan
- Integrated Business Plan (IBP) (draft)
- Long Term Financial Model (LTFM)

This paper provides an update on the current status of these documents, and the previous consideration they have received at Board level. Each of the items listed above will be signed off by the Chief Executive and Director of Finance and Performance Management before the submission is made to the TDA.

2 PREVIOUS CONSIDERATION

2.1 The five year plan summary is an extension of the two year plan summary that was approved by Trust Board on 3rd April 2014. The five year plan requires the following additional detail:

- Local health economy factors, competitive position, strategic developments, transactions and organisational sustainability
- Our clinical strategy including service line management, clinical networks and clinical sustainability
- Productivity and efficiency including benchmarked position and cost improvements
- Longer term financial sustainability, income, costs, activity, capital and risk mitigation
- Organisational relationships and capability including patient and public engagement, relationships with stakeholders and leadership development

2.2 Each of these elements are being reviewed and signed off by the relevant Executive Director.

2.3 The five year workforce and activity plans are extensions of the respective two year plans submitted to the TDA in April 2014, and cover the years 2014/15 – 2018/19. These plans were made available for Board review following the Board meetings of 6th March and 3rd April where papers were presented on the TDA submission requirements.

3 IBP & LTFM

3.1 The Trust's IBP has been redeveloped and is currently being produced by an external designer.

3.2 The finance chapter (chapter 6) is still under development due to the revisions being made to the LTFM. This is expected to be completed by the end of May 2014.

3.3 Relevant leads have met to discuss consistency across the IBP chapters, LTFM and planning templates.

3.3 Both the IBP & LTFM will return to Trust Board following TDA feedback, as these documents are required for the FT application process. It is expected that the next submission of the IBP & LTFM to the TDA will take place in September 2014. The Board can expect to receive these items at the Board meeting on 4th September 2014 for approval.

4 RECOMMENDATION(S)

4.1 To note the submission requirements for the TDA planning return (20th June 2014).

Tony Waite
Director of Finance & Performance Management
28th May 2014

Public Health, Community Development & Equalities Committee – Version 0.1

Venue D29 Meeting Room, City Hospital **Date** 27 February 2014 at 1400h

Members present		In attendance	Secretariat
Mr R Samuda	[Chair]	Dr D Robertson	Mr S Grainger-Lloyd
Dr S Sahota		Dr J Middleton	
Mr T Lewis			
Mr C Ovington			
Mr M Sharon			

Minutes	Paper Reference
1 Apologies	**Verbal**
Apologies for absence were received from Dr Roger Stedman, Mrs Gianjeet Hunjan and Mrs Chris Rickards.	
2 Public Health Plan 2014 - 17	**SWBPH (2/14) 002** **SWBPH (2/14) 002 (a)**
Referring to Dr Middleton's presentation, Mr Lewis noted that in terms of the ambition around smoking, that as the smoking cessation offer for staff was not well embedded, this was insufficiently clear and therefore the smoke free intention was set to be 2018 to allow improvement in this. Mr Lewis suggested that CO monitoring should be added into the plans. On discussion of the delivery of the 'Making Every Contact Count', it was highlighted that this was a significant challenge and this should be an immediate focus. Dr Robertson reported that it was supported nationally and had a history of engagement and impact. Mr Lewis noted the cultural challenge given that there was often not a feedback loop to demonstrate the impact of the 'Making Every Contact Count' model. It was suggested that breastfeeding ambition needed to be reinforced within the strategy. Mr Samuda added that exercise at a young age needed to be reflected, using role models within the Trust where possible. Dr Middleton suggested that a	

breakdown of performance by geography may be possible. Mr Lewis advised that trajectories would be set for the key targets in the strategy by the Executive Group and would be presented at the May meeting of the committee. Mr Samuda encouraged the use of innovative techniques to deliver the messages of the strategy. It was suggested that some of the key messages could be delivered using some advanced information technology and offering practical skills to assist with supporting the changes required. Dr Sahota asked what measures were in place to capture specific issues in communities, such as the use of fat and cholesterol. Dr Robertson noted the link to the management of the long term conditions. Mr Lewis advised that this was a parallel strategy, concerning revisions to the food provision for staff and patients. The unpopularity of these plans and the associated financial risks were outlined. In terms of next steps, Mr Lewis reported that the strategy would be launched and the objectives would be given a clear delivery plan and a trajectory that was realistic. It was highlighted that the focus would be on MECC and on staff. It was reported that the performance against the targets would be monitored through the corporate performance dashboard.	
ACTION: Dr Stedman to present the trajectories against the key targets in the public health plan at the May meeting of the Committee	
3 Equality proposal	**SWBPH (2/14) 003** **SWBPH (2/14) 003 (a) -** **SWBPH (2/14) 003 (c)**
Mr Ovington presented an overview of the Trust's equality and diversity framework, including the annual report which declared the position against the equality duties which had been published on the website. It was reported that work on the demographic required further attention. The Committee was asked to receive and approve the equality impact assessment toolkit which was used to apply to the Trust's services and policies from a top down approach. It was noted that Ms Dutton had commented that further focus was needed on equality within the Trust's decision making. The observation was concluded to be accurate, however it hoped to be addressed through the establishment of the Committee. Mr Ovington advised that further work was needed to ensure that the adoption of equality duties and requirements was Trustwide more robustly. He advised that an internal assessment would be undertaken as to the position which would be verified by an external body. Mr Sharon noted the similarity of the culture of equality & diversity with that of	

risk management and suggested that practices could be shared where possible. It was agreed that best practice from other organisations be investigated. Mr Lewis observed the differences in the local demographic in which the Trust was located to that in other parts of the country and therefore there was a requirement for the Trust to excel in terms of equality and diversity matters. It was agreed that a resource platform needed to be finalised to support the work and that an ambitious work plan was needed for the area that was over above the equality delivery system (EDS) requirements. In terms of the annual report, Mr Lewis suggested that patient demographic data was needed for inclusion. Dr Sahota agreed with the approach planned to reinvigorate the equality and diversity framework. He observed that in terms of the menu provisions for patients, a full range of choices was needed to cater for the different cultures. Mr Ovington highlighted the link with the patient satisfaction survey in this respect. Mr Lewis encouraged the thinking to encompass all protected characteristics rather than focus solely on religion and ethnicity. It was agreed that equality training was needed for the Board and the Executive. Mr Grainger-Lloyd was asked to arrange a specific training session in this respect.	
ACTION: **Mr Grainger-Lloyd to arrange a session for the Board and the Executive for equality & diversity training** **ACTION:** **Mr Ovington to present an update on the plans to reinvigorate the equality and diversity framework at the next meeting**	
4 Proposal for the engagement of volunteers	**SWBPH (2/14) 004**
Mr Ovington presented a position statement in terms of the Trust's engagement of volunteers, highlighting that further work was needed in this area. He suggested that the volunteers needed to be branded as being part of the Trust to ensure that the individuals felt part of the organisation. Dr Sahota noted the opportunity to use volunteers as part of the plans for the new hospital and within the Trust to provide wayfinding facilities. Mr Samuda highlighted the need to provide a robust infrastructure to support the volunteers to ensure that the individuals were retained and deliver an appropriate contribution. Mr Ovington advised that in other trusts, volunteers were used to assist with feeding patients and provide wayfinding. Dr Sahota provided some examples of organisations with which he was familiar which used volunteers for different reasons. Mr Lewis suggested that gaps that could be filled by volunteers needed to be identified by the Trust's staff. It was noted that the plans needed to include the	

WRVS. In terms of timing, it was agreed that this needed to be discussed with the Executive Group, however the plans needed to progress through Quarter 1.	
ACTION: Mr Ovington to present an update on the plans to reinvigorate the Trust's volunteer offering at the next meeting	
5 Sandwell Public Health update	**Presentation**
Dr Middleton provided an overview of the current and future position in terms of public health indicators in Sandwell. Improvement against a number of indicators was noted including excess winter deaths. The key challenges that would be addressed by the Trust's Public Heath strategy were discussed. It was noted that the efforts to combat smoking in pregnancy, corporate citizenship & sustainable development, the alcohol ambition and measures to improve the health of staff were particularly significant in this respect. Mr Lewis asked what interventions would be needed to address infant mortality. Dr Middleton advised that the reconfigured children's service would be likely to deliver benefit in this area. It was noted that addressing smoking during pregnancy and maternal obesity would assist with improving performance against this indicator. Dr Middleton was thanked for his attendance and presentation.	
6 Workshop: community development	**Discussion**
Mr Samuda reported that a number of community developments had been discussed at a recent Healthwatch event. It was agreed that this information could be used to form the Trust's future plans. Mr Lewis highlighted that a map of the community was needed which highlighted the key communities and connections which the Trust could access. It was agreed that the resources for this purpose were needed. Dr Robertson suggested that a brainstorming exercise was needed to gather the information together from a number of staff across the Trust, including chaplains, interpreters, business development staff and voluntary sectors. It was agreed that the plans needed to be discussed with the Executive Group. Dr Sahota recommended that some of the existing infrastructure in local authorities could be accessed.	
7 Matters to raise to the Board	**Verbal**
It was agreed that the equality position needed to feature prominently in the feedback to the Board.	
8 Any other business	**Verbal**
There was none.	

9 Details of the next meeting	Verbal
The next meeting is to be held on 29 May 2014 at 1400h in the D29 (Corporate Suite) Meeting Room, at City Hospital.	

Signed ……………………………………………………………………………………………..

Print ……………………………………………………………………………………………..

Date ……………………………………………………………………………………………..

Quality and Safety Committee – Version 0.1

Venue D29 Meeting Room, City Hospital **Date** 25 April 2014; 1030h – 1230h

Present
Ms O Dutton
Ms G Hunjan
Mr R Samuda
Dr S Sahota OBE
Mr C Ovington
Mr T Waite
Miss K Dhami

In Attendance
Dr C Cobb
Mrs D Talbot
Mr M Harding
Mr G Smith

Secretariat
Mr S Grainger-Lloyd

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
Apologies for absence were received from Dr Stedman, Miss Barlow and Ms Binns.	
2 Minutes of the previous meeting	**SWBQS (3/14) 035**
The minutes of the Quality and Safety Committee meeting held on 28 March 2014 were approved as a true and accurate reflection of discussions held.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**SWBQS (3/14) 035 (a)**
The updated actions list was received and noted by the Committee. It was reported that discussions had been held with the Coroner through the Head of Legal Services, however it was agreed that the two local coroners should be invited to join the Board at a future meeting to discuss learning points. It was agreed that Miss Dhami would address this matter.	
ACTION: Miss Dhami to invite the coroner to join a future informal meeting of the Trust Board	

MATTERS FOR DISCUSSION/DEBATE	
4 Corporate quality and performance dashboard	**SWBQS (4/14) 037** **SWBQS (4/14) 037 (a)**
Mr Harding presented the end of year corporate quality and performance dashboard. He highlighted that Emergency Care performance for the month was 96% which excludes any GP deflect activity and with this included, this would be likely to improve the position by c.0.4%. It was reported that in March a breach of the 28-day cancelled operation guarantee had been reported and a root cause analysis had been commissioned to understand the reasons for the issue. An update on this was requested for the next meeting. Dr Sahota asked whether activity had been taken into account as part of the consideration of performance against the cancelled operations target. He was advised that performance against the target was expressed as a percentage of activity. The Committee was advised that there had been an increase in the number of single sex accommodation breaches, noting that this reflected to some degree the introduction of new technology to improve reporting. Mr Ovington reported that a number of these breaches included stroke care environment. In terms of performance against CQUIN targets, it was noted that the medicines management target had not been achieved. Ms Dutton noted the significance of the risks around not achieving this target. It was noted that there were no common themes to these breaches. Ms Dutton asked for the details of the accountability line for this issue. She was advised that all nurses that were responsible for holding the keys to the drugs cabinets were accountable and that Group Directors of Operations had been engaged in this approach. Mrs Talbot advised that a safety check sheet was also in place which aimed to capture compliance. It was reported that £741k of funds was attached to the shortfall against the target which the Committee agreed was an unfortunate loss. The most recent response rate in maternity to the Friends and Family Test was reported to remain disappointing. An improvement in performance against the dementia target was reported to have occurred throughout the year, although performance during the last month was reported to have deteriorated to some degree. It was agreed that the performance against the fractured neck of femur target needed to be explained to the Board at its meeting on 1 May. Ms Dhami reported that the closure of the Central Alerting System (CAS) alerts was largely on track although she promised a fuller update at the next meeting. Mrs Hunjan noted that the Trust was not performing well against the sickness absence targets. It was noted that against the Trust Development Authority target there was not a concern, although it was acknowledged that performance against	

the previously set regional targets remained poorer than desired. Dr Sahota noted that there was underperformance against the ambulance turnaround target, which it was noted could attract a financial penalty. Ms Dutton noted that there was underperformance against the sepsis care bundle target, which was concerning. Mr Ovington advised that a detailed review of this was planned for the next Patient Safety Committee. Dr Sahota noted that the issue had been a concern of the Committee for a number of months. It was agreed that a more detailed report would be presented at the next Committee meeting. Ms Dutton asked for further detail of performance against the thrombolysis target. Mr Harding reported that although a performance of 85% was not being met although the position had improved considerably during the year and plans were being put into place to deliver a further improvement over the next few months. It was reported that overall performance against the stroke care targets was being maintained. Dr Sahota noted that the use of bank and agency staff remained high and this was of concern given the changes in respect of the VAT regulations. Mr Waite reported that it was likely that it was likely that the proposed VAT changes might be deferred. Mrs Hunjan sought assurance that performance against the complaints handling targets was acceptable. Miss Dhami provided an overview of the position, using the weekly sitrep to illustrate. It was noted that further detail on cardiology performance was required.	
5 Quality Account 2013/14	**SWBQS (4/14) 038** **SWBQS (4/14) 038 (a)** **SWBQS (4/14) 038 (b)**
Mr Ovington provided an overview of the process for the development and review of the Trust's Quality Account. It was noted that further information concerning benchmarking had been included in the report for 2013/14. The Committee was advised that the format and flow of the document was pre-prescribed. It was noted that the document would be issued for formal public consultation shortly prior to being considered by external audit who would audit two specific indicators (*C difficile* and VTE assessment). Dr Sahota noted that the Quality Account included some terminology and acronyms. He was advised that a glossary had been included. All were asked to provide feedback if needed as soon as possible. It was suggested that a plain English summary of the Quality Account would be beneficial to give out to patients, such as quality standards. Some presentational comments were received. It was suggested that some overall governance matters needed to be included,	

however it was pointed out that the Annual Governance Statement was included as an annex to the report. Ms Dutton suggested that an inclusion around integration plans needed to be included. Miss Dhami suggested that this could be included within the Chairman's and Chief Executive's statement. The Committee agreed that the report needed to be accessible on the intranet and be searchable.	
6 Draft integrated quality, finance and performance dashboard	**SWBQS (4/14) 039** **SWBQS (4/14) 039 (a)**
The Committee received and noted the revised integrated quality, finance and performance dashboard. It was noted that the work remained a work in progress, including the increased use of peer comparator information and the inclusion of a kite mark indicator assessment. The Committee was advised that parallel use of the current performance dashboard would continue with a view to ceasing this during Quarter 1. Ms Dutton suggested that a read across between the Quality Account and the integrated performance report was needed to ensure more ease of cross referencing. It was suggested that there should be consistency between the targets in the report with that with the Quality Account. Mr Harding advised that a similar report had been prepared at a directorate level for the Group review meetings. Mr Waite advised that a granular view of some of the KPIs, such as those for mortality, as part of the work of Capita in the report could be included as part of the next iteration. It was agreed that Mr Harding should present a further version of the integrated quality, finance and performance dashboard at the next meeting which included the feedback received.	
ACTION: Mr Harding to present a further version of the integrated quality, finance and performance dashboard at the next meeting	
7 Cardiology recovery plans	**SWBQS (4/14) 040** **SWBQS (4/14) 040 (a)**
Mr Ovington presented the position statement of the cardiology speciality recovery plan. It was noted that good progress had been made overall, although some actions remained off track. Ms Dutton noted that the timescale for the action plan had been extended significantly and asked that the Executive to consider whether the original targets had been overly ambitious and whether the proposed extension to the end of May was truly achievable. Miss Dhami encouraged these timescale considerations to be made in the context of patient impact such as	

complaints and incidents. Mr Waite noted that the end of the action plan needed to be aligned with the Trust's contractual obligations. Mr Samuda suggested that the matter needed to be raised with the Trust's commissioners. Miss Dhami suggested that it should be added to the agenda of the next Clinical Quality Review meeting. It was also agreed that the Committee would benefit from the presence of the appropriate clinical group to assist with discussions around matters such as this.	
8 2014/15 TSP – Quality Impact Assessment update	**Verbal**
It was reported that there had been no further schemes that had needed to have been signed off since the last meeting. Mr Waite advised that Quarter 1 would be used to remedy the shortfall in the TSP quantum and that external bodies had been engaged to assist with this work. Mrs Hunjan suggested that consideration needed to be given to monitoring the ongoing quality impact of the TSP schemes. Mr Ovington advised that a structure was not currently in place to facilitate this ongoing monitoring and that further consideration needed to be given to establishing this. Miss Dhami advised that as part of the development of the Transformation Programme Reporting System (TPRS) had included the indicators that needed to be monitored. Mr Waite agreed that this matter needed to be further considered. It was agreed that a further update on these plans needed to be presented at a future meeting following a discussion with Dr Stedman.	
9 Committee observations by Deloitte – decision on recommendations	**SWBQS (4/14) 041**
The Committee agreed that consideration to alternative venue for the meetings needed to be considered in the event that there were a significant number of guests. Ms Dutton suggested that the serious incidents and complaints reports should be received for information in future, on the basis that on a quarterly basis a lessons-learned/trends report would be presented. It was agreed that the first report should be received in June.	
ACTION: Miss Dhami to present a quarterly lessons learned & trends report at the June meeting of the committee	
10 Serious Incident report	**SWBQS (4/14) 042** **SWBQS (4/14) 042 (a)**
The Committee was asked to receive and note the serious incident report.	
OTHER MATTERS	
11 Matters of topical or national media interest	**Verbal**

Mr Samuda asked how some of the responses to national studies were handled when published. It was reported that the Clinical Effectiveness team oversaw the process through the NICE Implementation Group and the Clinical Effectiveness Committee. Dr Cobb described the process regarding the mortality alerts that were received. Miss Dhami suggested that a list of the national publications and the relevant clinical leads should be included for consideration by the Committee in future. Dr Sahota reported that there was an outbreak of a respiratory disorder at present that emerged from Saudi Arabia. Dr Cobb advised that the clinical assessment would usually pick up any recent visits abroad. Mrs Talbot advised that a 'flu assessment checklist had been developed which might capture this.	
ACTION: **Miss Dhami to arrange for a list of the national publications and relevant clinical leads to be presented at a future meeting of the Committee**	
12 Matters to raise to the Board	**Verbal**
It was noted that there were several matters to raise to the Board. Ms Dutton suggested that the common themes arising from the patient stories needed to be considered on a quarterly basis.	
ACTION: **Mr Ovington to present a quarterly update discussing the common themes arising from the patient stories considered by the Board**	
13 Any other business	**Verbal**
There was none.	
14 Details of the next meeting	**Verbal**
The date of the next meeting of the Quality and Safety Committee was reported to be 30 May 2014 at 1030h in the D29 (Corporate Suite) Meeting Room, City Hospital.	

Signed ……………………………………………………………………

Print ……………………………………………………………………

Date ……………………………………………………………………

Finance & Investment Committee – Version 0.1

Venue D29 Meeting Room, City Hospital **Date** 28 March 2014; 0800 – 1000h

Present

Ms Clare Robinson
Mr Richard Samuda
Mr Harjinder Kang
Mr Tony Waite
Ms Rachel Barlow

In attendance

Mr Chris Archer
Mr Toby Lewis

Secretariat

Mr Simon Grainger-Lloyd

Minutes	**Paper Reference**
1 Apologies for Absence	**Verbal**
Mr Sharon's apologies were tendered.	
2 Minutes from the previous meeting	**SWBFI (1/14) 011**
The minutes of the meeting held on 31 January 2014 were accepted as a true and accurate record of discussions held.	
AGREEMENT: The minutes of the previous meeting were accepted as a true and accurate reflection of the discussions held	
3 Matters arising from previous meeting	**SWBFI (1/14) 011 (a)**
The Committee was asked to receive and note the action tracker. In terms of the contracts database, it was agreed that Mr Waite would assess whether it was feasible for the work to be fully completed by the end of May 2014. Ms Robinson asked that a further update on the mechanisms for monitoring the use of bank and agency staff be presented at a future meeting of the Committee. Additionally, it was agreed that recruitment times should be presented at the Workforce & OD Committee on 28 March. Mr Lewis advised that good progress was being made to reduce the previous 18 weeks' time to recruit as evidenced by tracking being undertaken by the Workforce department. It was agreed that the forward cycle of business should be considered under any	

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other business.	
ACTION: **Mr Waite to assess whether it was feasible for the population of the contracts database to be completed by the end of May 2014** **ACTION:** **Miss Barlow to provide an update on the mechanisms by which temporary staff usage is monitored**	
3.1 Winter funding vs. capacity	**Verbal**
Miss Barlow reported that from a financial perspective, it was estimated that c. £450k would have been spend on the additional bed days, the funding for which would be largely incorporated within the end of year settlement with Sandwell CCG. Ms Robinson noted that clarity was needed to assess the impact of delays caused by outside agencies from a financial and patient experience perspective. Mr Lewis suggested that there was a possibility that the costs associated with the opening of beds over and above the Trust's intentions could be more robustly reimbursed in winter 2014. It was additionally advised that fines would be levied to Social Services by the Trust for delayed transfers of care shortly. Mr Lewis advised that to close the planned number of beds in 2014/15, the number of delayed transfers of care needed to reduce significantly and that this could be tracked through the corporate performance report and the urgent care scorecard. It was agreed that the winter plan should be presented at the July meeting of the Finance & Investment Committee and the Trust Board. The use of nursing home capacity was also reported to be being investigated.	
ACTION: **Miss Barlow to present the 2014/15 winter plan at the July meetings of the Financial & Investment Committee and the Trust Board**	
4 2014/15	
4.1 Financial plan 2014/15	**Hard copy**
Mr Waite reported that significant work had been undertaken to understand the impact of the current financial year's position on the forthcoming financial year. It was noted that the financial contract with commissioners had been agreed and therefore the income position was understood. The Committee was asked to note that at present there were £12m of cost savings that had been identified, leaving a significant element of the required savings totals remaining to be identified. It was reported that external support and some additional internal controls would be used to assist with delivering the cost savings required. Mr Lewis advised that a route to an overall TSP requirement of £20m had been identified, although the certainty of the changes required was less certain. He suggested that the measures needed to close the current gap of £8m needed to be identified, a process which would be completed by July 2014. Work was reported to be planned to close the organisation's perception between changes required and the financial impact that followed, a matter which would be assisted through the use of very targeted resources secured from both internal and	

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external sources over an eight week period.

Mr Lewis suggested that the Committee should provide close scrutiny on the development of the full savings plan, particularly during the first quarter of 2014/15. It was agreed that the matter needed to be raised to the Board at its meeting on 3 April.

Ms Robinson noted that there was an upside potential and asked what mechanisms were in place to ensure that the opportunity was maximised. Mr Waite advised that the position related to achievement of operational standards and that monitoring mechanisms were in place to ensure that performance was tracked and financial penalties highlighted where applicable. Ms Robinson asked how the Committee could monitor this matter. She was directed to the corporate performance dashboard which outlined performance against some of the contractual targets. Miss Barlow outlined additional measures over and above the performance report that were in place to monitor the position. It was noted that the plan would next be considered by the Board on 3 April and that the risks around the plan should feature within the Board Assurance Framework in terms of scale and pace of delivery.

It was agreed that the detailed capital programme should be presented at the May meeting of the Board.

Mr Waite reported that there appeared to be greater financial stress in other parts of the region. It was highlighted that the Better Care Fund was a preoccupation of many organisations at present.

ACTION: **Mr Waite to present the capital plan at the May meeting of the Trust Board**

5 2013/14

5.1 2013/14 Month 11 financial position, including year-end forecast CapEx position

SWBFI (3/14) 013
SWBFI (3/14) 013 (a) - SWBFI (3/14) 013 (e)

Mr Waite reported that all key statutory targets were expected to be met by the year end, with a Continuity of Service Risk Rating of 4. In securing the end of year surplus, it was reported that some resources had been released and flexibilities used to underpin the position, which it was noted included site clearance costs that had not been required as anticipated. The end of year contract settlement was reported to have been concluded for 2013/14.

The paybill was reported to be as expected and creditor payments were in line with plan.

Mr Kang noted that the capital expenditure position, where there was significant underspend, represented a significant concern. Mr Waite advised that more robust attention would be given to the profile of this spend in the forthcoming financial year. Ms Robinson asked given that over 50% of the capital spend was planned for the final month of the year, how the risk around securing best value for money was gained from the spend. Mr Waite advised that significant attention had been given to medical equipment spend to ensure that value for

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money was achieved. Mr Lewis acknowledged that the position was unacceptable and that named Executive leads would be allocated to the spend in 2014/15 which would provide closer oversight and accountability for the spend. It was agreed that a detailed report on the capital plan spend should be presented at the forthcoming meetings, including details of the controls being out into place to manage the profile of the spend. It was agreed that the commercial arrangements and procurement implications of the position needed to be understood in this respect. In terms of payment against the better practice code, it was agreed that a report should be presented at a future meeting to outline the reasons behind not meeting the target. It was agreed that a list of priority key topics that concerned the Committee should be presented at a future meeting of the Committee. Mr Samuda noted that there had been an underspend on Therapies pay. Miss Barlow advised that this reflected the current comprehensive workforce review that was underway in this area. Mr Lewis suggested that attention needed to be given to non-pay expenditure. Mr Archer advised that the high cost drugs overspend was offset with an equal amount of income to compensate. In terms of medical equipment and consumables, there was a degree of income offset and that judgements could be made as to the element that related to direct access, however it was noted that this did not fully explain the position where there were some significant variances in spend. Mr Lewis noted that the non-pay spend was uneven and therefore more robust tracking in 2014/15 was necessary, a matter on which Mr Waite would lead. Ms Robinson asked that attention be given to postage, printing and stationery controls. It was noted that a new methodology would be adopted for the issuing of letters to patients in 2014/15. Ms Robinson, referring to the spend on bank and agency staff, noted that the position appeared to be escalating. Miss Barlow advised that the increase in healthcare assistant pay costs for 'specialling' patients contributed to this position and that Mr Ovington was considering this. Mr Lewis added that an additional set of controls would be put into place which would introduce an Executive-level approval to the use of bank and agency staff, including medical bank and agency staff. It was noted that this would be accompanied by measures to expedite the appointment of substantive staff into key positions to reduce the reliance on temporary staffing. It was reported that a weekly bank and agency staff utilisation report would be prepared to monitor the position. Miss Barlow added that waiting list initiatives would also be signed off by the Chief Operating Officer which was also anticipated to deliver an improvement in the use of bank and agency staff. It was noted that the Orthopaedics speciality had undertaken some significant preparation work as part of these plans. It was agreed that the Committee should continue to act as a 'critical friend' to the plans being put into place to better control bank and agency spend. Ms Robinson suggested that the impact on the higher than planned activity needed to be given focus. It was agreed that a robust set of management information was needed to show this impact through data. Mr Kang asked at	

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what point the variance in activity triggered a discussion with the commissioners.	
ACTION: **Mr Waite to present a report on capital spend to the future meetings of the Finance & Investment Committee** **ACTION:** **Mr Waite to present a report the position and planned improvements to deliver against the Better Payment Practice Code at a future meeting** **ACTION:** **Mr Waite to present the list of matters that the Committee should concern itself with most at a future meeting**	
5.2 TSP delivery report 2013/14	**SWBFI (3/14) 014** **SWBFI (3/14) 014 (a)** **SWBFI (3/14) 014 (b)**
Ms Robinson noted that SA217, the plan to move sickness rates in the Surgery A Group did not align with the overall sickness absence rates and suggested that this was a matter that needed to be joined up as part of the 2014/15 Transformation Plan. She was advised that this link would be created.	
5.3 Restructuring costs and year end provisions	**SWBFI (3/14) 015** **SWBFI (3/14) 015 (a)** **SWBFI (3/14) 015 (b)**
Mr Waite reported that a provision needed to be made for restructuring in the current financial year's budget and that a set of TSP proposals had been developed which my result in redundancy costs being paid. The approach taken was reported to be consistent with that taken in previous years and would be subject to scrutiny from external audit. The Committee approved the proposed provision for redundancy costs. It was noted that the plans would be presented at the Board meeting on 3 April.	
5.4 Draft integrated quality, finance and performance monitoring report	**SWBFI (3/14) 017** **SWBFI (3/14) 017 (a)**
The Committee noted the next iteration of the quality, finance and performance monitoring report. It was noted that a substantive discussion of the report would be held at the Quality & Safety Committee. The Committee welcomed the planned changes. Mr Archer suggested that a rolling twelve month view needed to be built into the report. Miss Barlow suggested that measuring against the improvement plans might be appropriate to include.	
5.5 Financial risks to the organisation	**Verbal**
The financial risks were noted to concern those related to the development of the financial plan for 2014	
6 Matters for information	
6.1 Committee observations from Deloitte Board Development work	**SWBFI (3/14) 018**

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The Committee received and noted the recommendations made in relation to the Finance & Investment Committee. It was noted that a rounded debate had been undertaken at the meeting observed.	
7 Matters to highlight to the Board	**Verbal**
The Committee had discussed the financial position for Month 11; the TSP update for 2013/14; the plans for restructuring costs provisions and the refreshed integrated report. It was noted that the Committee had noted the financial plan and the risks associated with this.	
8 Meeting effectiveness feedback	**Verbal**
It was agreed that the meeting had been productive.	
9 Any Other Business	**Verbal**
There was none. In terms of the cycle of business, it was agreed that a meeting was needed to provide additional focus on the savings plan. It was agreed that feedback on the procurement strategy would be provided in October, with feedback against the capital plan being provided on a monthly basis until then. It was suggested that a mid-year stocktake was needed on the financial plan which would inform the development of the 2015/16 plan. It was agreed that the lessons learned needed to be considered.	
ACTION: Mr Grainger-Lloyd to arrange a further meeting of the Finance & Investment Committee in May to discuss the savings plan development	
10 Details of the next meeting	
The next meeting of the Finance and Investment Committee was noted to be scheduled for 30 May 2014 at 0800h in the D29 (Corporate Suite) meeting room at City Hospital.	

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Signed: ………………………………………………………………….

Name: ………………………………………………………………….

Date: …………………………………………………………………

Finance & Investment Committee – Extraordinary Meeeting – Version 0.1

Venue Anne Gibson Boardroom, City Hospital **Date** 16 May 2014; 1200 – 1330h

Present

Ms Clare Robinson
Mr Richard Samuda
Mr Tony Waite

In attendance

Dr Sarindar Sahota
Mrs Gianjeet Hunjan
Ms Olwen Dutton
Mr Toby Lewis
Mr Colin Ovington
Dr Roger Stedman
Mrs Jayne Dunn

Secretariat

Mr Simon Grainger-Lloyd

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Minutes	Paper Reference
1 Apologies for Absence	**Verbal**
Apologies were received from Mike Hoare, Paramjit Gill, Harjinder Kang, Kam Dhami and Rachel Barlow.	
2 2014/15 Transformation Savings Plan	**Presentation**
Mr Lewis reminded colleagues of the context to the meeting, in that it had been understood that historically the system to manage the Trust's financial position relied on arrangements with the CCG for income provision, alongside a system that generated cost savings internally. It was noted that although this had been purposeful in the past, it did not focus on reducing costs incurred on a year on year basis. Additionally, it was noted that the Commissioning landscape had changed significantly in terms of contractual arrangements with inflation no longer being funded. He added that to ensure that the financial position remained viable, a significant challenge was faced in the current year. Mr Waite guided the Board through the presentation 'Safely balancing our finances in 2014/15'. It was reported that some historic contractual arrangements had unwound therefore requiring a change in approach during the current year. It	

was reported that some non-recurrent flexibility and real cost reduction was necessary over the forthcoming years. The Committee was advised that the current effort was remedying 2014/15 position with a view to resolving the forward position in subsequent years. Mr Waite reported that there were some behaviours which need to be reinforced to drive the approach required. It was reported that resources were being directed to assisting with the work which were sourced from external sources. Financial success was noted to be living within budgeted resources and doing this across all parts of the organisation, rather than at a whole organisation level, without any compromise to safety.

Progress with the development of the Transformation Savings Plan currently made to date was articulated to be £14.1m identified against the £21m. The level of confidence in the schemes was outlined to be satisfactory in terms of quality and financial perspectives, however it was noted that there remained a significant gap to address. Progress across the organisation was outlined including the challenges with engagement in some parts requiring a variation in approach between areas.

A savings profile against the TDA plan was discussed which was noted to fall short later in 2014/15. Value of schemes on system for first quarter was highlighted to suggest a significant shortfall, with £168k shortfall expected in April. It was highlighted that there was some tightening up of process to provide a robust basis for triangulating real progress. It was also highlighted that there was a tightening up of control in terms of spend as well. A series of austerity measures and controls was reported to have been put into place which included control of temporary staff.

All schemes were reported to have a named project lead. Progress on QIA and EIA was reported to be good with all schemes having been subject to these processes and scrutiny.

Dr Sahota noted that historically there had been much pressure in Medicine and Surgery Groups and asked whether there would be a need to ensure that the issues in the past, such as reopening wards had been taken into account as part of the plans. Mr Lewis commented that the challenge was distributed across the organisation rather than being focussed on the Medicine Group soley. He added that the schemes had been scrutinised for dependencies and in terms of the medicine plans, there were a large number of linkages identified. It was highlighted that there was a commitment to closing beds informed by the granular view of the schemes. Dr Sahota asked if there was contingency if additional beds needed to be opened as they had in the past. Mr Waite advised that good insight through clinical benchmarking suggested that there was an opportunity to improve which translated into operational change, such as the bed closures and financial benefits associated with this. Mr Lewis advised that the actions needed would be similar to those planned previously but with better implementation plans.

Mrs Hunjan noted that some of the gap reflected the need for better engagement and asked for a sense of whether these areas tied with those experiencing poor TSP identification. Mr Waite acknowledged that there was differential engagement. Intensive support was reported to being directed to Surgery A

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Group and for the Women and Child Health Group an opportunity analysis was being undertaken. Mr Ovington reported that as part of the QIA process there had been good engagement, however penetration lower down was needed. Mrs Hunjan asked whether there were any areas of risk by removing some WTEs as part of the schemes. Dr Stedman reported that this was analysed as part of the QIA process, with schemes not being approved if the risks proved unmanageable. Mr Lewis advised that an ongoing QIA process was necessary, with them being monitored on a quarterly basis. Ms Dutton supported this approach. Mrs Hunjan asked in terms of service line reporting, how the process tied together. Mr Waite reported that this would have merit as part of the opportunity.

The plans for closing the gap by the end of May were discussed. It was reported that resolution of the gap would be given oversight by the Executive and a different approach would be taken to that previously, with clinical benchmarking, reviewing nurse staffing, service line review and looking at procurement. Intensive support was reported to be directed to some areas where this approach was seen to be valuable. Mrs Dunn guided the Committee through the programme of work planned, including strengthening the governance and programme management arrangements. Mr Lewis advised that a basic set of ideas by the start of June was needed to work through the detail with a view to executing the plans. It was reported that staffing would be reviewed in a number of areas.

Ms Robinson asked what the concerns were over the plans. Mr Ovington reported that execution of the senior staff's 'day job' along with the work to address the gap closure presented a significant concern. Dr Stedman advised that some work previously planned, would need to be deferred, such as a review of the HIS capital programme plans in order to better direct effort to enabling technologies such as developments on EBMS. Mr Lewis agreed that an articulation of the consequences of the plans would be developed, including matters being deferred, which included the risks of the work. The Committee was advised that attention of the senior management team would be directed to resolving this which may give rise to a perception that previous priorities had been deferred. Ms Dutton suggested that the challenge was significant within a short period of very focussed activity and therefore she asked whether it was appropriate to hold the Leadership Conference in the middle of the work. Mr Lewis agreed to consider this suggestion, however he advised that the long term strategy would be considered at this event which was of critical importance. Ms Robinson noted the need for careful and clear message associated with the programme of work. Mr Lewis acknowledged that there was not yet a sufficiently clear message on the financial position for communication to the Trust which he suggested needed to be focussed not just on 2014/15 but also on the subsequent year. Mr Ovington reported that benefits of the schemes had been identified in addition to risks. Dr Stedman advised that some schemes contained little risk.

Mr Waite outlined the procurement review plans which would receive a coherent and comprehensive workplan for this area.

The forward governance plans for the work were discussed, particularly how assurance that adequate risk management arrangements were in place. In terms of the role of the Finance & Investment Committee, it was agreed that the

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progress with the delivery of the LTFM was to be discussed at the meetings and the progress with the delivery of the savings plans was necessary across 14/15 and 15/16. Ms Dutton asked whether some of the 14/15 work would provide enablers for 15/16. Mrs Dunn agreed that this was the case and noted that the enabling work was needed as soon as possible to deliver the deeper changes as part of the process. Ms Dutton noted the impact needed to be considered cumulatively across the timescale. Ms Robinson suggested that savings extracted from schemes historically needed to be considered as part of making up the gap. Mrs Hunjan noted that a stretch target was planned into the LTFM. It was acknowledged that this ambition was still present, making the value £24m, some of this being related to the financial risks in the annual financial plan. Ms Dutton emphasised the need to continue to underline the Trust's number one priority as being quality and safety. Mr Lewis agreed that this was necessary and there was a need to retain oversight on local decision making. It was agreed that a view of the situation from the perspective of middle managers could be taken by the Non Executives in October. Ms Dutton expressed her concern over the Imaging position. Mr Lewis advised that the area was currently without a Director of Operations, however the capability of the Group was improving. Mr Samuda suggested that the Board agenda needed to be focussed on these matters. It was agreed that a view of 14/15 end year position and the planned 15/16 position was needed for the Board, including revisiting previous schemes to assess their effectiveness. Mr Lewis suggested that reconciliation against the Monitor guidance on delivery of a smart savings programme should be prepared. It was agreed that the responsibilities for the delivery of the schemes needed to be clarified in addition to the necessary monitoring function. It was agreed that the escalation process needed to be considered and that the quality/equality assessments needed to be clarified through the process. Training for project leads was reported to be being delivered at present. Mr Lewis suggested that scrutiny of the delivery of the plans to meet the financial targets and the achievement of real cost savings was needed from the FIC. It was suggested that this would be gleaned from the PMO documentation. Mrs Dunn advised that some of this work was linked to the Leadership Development work. Ms Robinson noted that the impact assessment needed to be universal rather than being targeted at some schemes and not others. She asked whether the best practice from some other trusts was being used and was advised that this was the case though the external resources. A steady state corporate PMO was reported to be needed by the end of May 2014. Mr Lewis suggested that there needed to be a focus on budget management training, including reading of management information, for relatively junior members of staff who were engaged in the process. Mr Samuda asked how the Finance team was being supported. He was advised that there was senior financial representation in the corporate PMO and financial support would also be made available to the local PMOs. Mr Waite reported that some of the challenge being felt in the main body of the organisation was also being experienced in the Finance team and that a change management process was being developed. It was agreed that the development of the PMO needed to be considered in future. Mr Ovington suggested that the Quality & Safety Committee considered the position against the quality indicators as part of the work. Mrs Hunjan noted that	

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the internal audit plan needed to be focussed to ensure it was being directed in the right areas. Mr Samuda underlined the need to secure a skills transfer from the external staff to internal.	
ACTION: **Executive to develop a coherent sent of messages for communication in relation to the Trust finances** **ACTION:** **The process for the ongoing assessment of the Quality Impact Assessment of TSP schemes to be presented at a future meeting of the FIC** **ACTION:** **The Executive to prepare a list of matters needing to be deferred as a result of the current plans to close the TSP gap** **ACTION:** **Prepare a reconciliation against the key indicators listed within the Monitor guidance on the delivery of robust cost improvement programmes** **AGREEMENT:** **The FIC to provide scrutiny of the delivery plans in place to meet the year's financial targets and achieve the cost savings required**	
3 Any Other Business	**Verbal**
There was none.	
4 Details of the next meeting	
The next meeting of the Finance and Investment Committee was noted to be scheduled for 30 May 2014 at 0800h in the D29 (Corporate Suite) meeting room at City Hospital.	

Signed: ……………………………………………………………

Name: ……………………………………………………………

Date: ……………………………………………………………

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Midland Metropolitan Hospital Status Report June 2014

Activities Last Period

- Approval process –DH OBC /commercial
- Continue fine tuning procurement documents

Planned Next Period

- Continue site demolitions
- Continue detailed site investigations
- Agree a communications plan with the executive
- Ensure project resourcing is in place to October 2018
- Mobilise the new clinical procurement team
- Progress the City site “separation for disposal” plan

Issues for Resolution/Risks for Next Period

Finalise Approvals before agreement to advertise scheme

SWBTB (6/14) 089

FT Programme Monitoring Status Report

Activities This Month

- Prospective FT Project Plans with timeline options to 05/2015 & 05/2016 & coherent with prospective MMH obligations.
- IBP chapters re-developed in line with OBC and additional annual planning returns in readiness for submission to the TDA on 20.06.14.

Planned Next Month

- BGAF & QGAF self-assessments at July Trust Board informal session (11.07.14)

Issues for Resolution/Risks for Next Month

- Confirmation of plan FT timeline with TDA
- Confirmation required from CQC as to likely timing of CIH visit
- Confirmation required from DH / HMT re MMH